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ABSTRACT

This document presents the proceedings of a conference whose objectives were: (1) to identify the interrelationship of certification, licensure and accreditation in the allied health professions; (2) to describe current practices and consider their advantages and disadvantages in light of public and professional needs; (3) to consider the purposes and effectiveness of certification in the allied health professions; (4) to identify general principles and policies used in the development and application of certification standards; and (5) to explore methods for increasing efficiency and economy in the certification process. (Author/HS)

CERTIFICATION IN ALLIED HEALTH PROFESSIONS

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1971 Conference Proceedings

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U. S. DEPARTMENT OF
HEALTH, EDUCATION,
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Public Health Service
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**CERTIFICATION IN
ALLIED HEALTH PROFESSIONS**

Proceedings
Invitational Conference
September 7-10, 1971

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service—National Institutes of Health
Bureau of Health Manpower Education
Division of Allied Health Manpower

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PREFACE

This publication presents materials included in the final report made to the Division of Allied Health Manpower by the Association of Schools of Allied Health Professions on NIH Contract 71-4155. The Association was the contractor for the Invitational Conference on Certification in Allied Health Professions which was held at the University of Maryland Continuing Education Center, September 7-10, 1971. The Proceedings are published in this format to provide a record of the Conference for the participants and others who will be interested in the occasion which brought allied health professions organizations together for the first time to discuss manpower certification issues. The Conference presentations and resource papers are included as they were submitted at the time of the Conference, with only minimal editing.

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CHAPTER I—CONFERENCE PLAN

INTRODUCTION TO THE CONFERENCE

This conference is planned to bring together representatives from selected national professional associations and certifying agencies, individuals from other organizations interested in the credentialing of personnel in the allied health professions and individuals from Federal agencies with activity related to allied health to provide for an interdisciplinary exploration of the conference subject. The general sessions will highlight the interface of the health care industry with other social systems and forces, delineate the needs for a credentialing process to parallel the changing health care system, and describe the current status of the certification process of the allied health professions.

Resource materials have been prepared to provide the conference participants easy access to relevant information.

The task groups will discuss various major factors related to credentialing and delineate recommendations for a future course of action.

We wish to take this opportunity to thank each person and organization involved for the cooperation received in this endeavor, and to express our hope and confidence that our joint efforts will lead to a progressive future for the allied health professions.

INVITATION LIST

American Association for Inhalation Therapy
American Association of Medical Assistants
American Association of Physician's Associates
American College of Hospital Administrators
American Corrective Therapy Association
American Dental Assistants Association
American Dental Hygienists Association
American Dietetic Association
American Medical Record Association
American Occupational Therapy Association
American Optometric Association
American Orthotics and Prosthetics Association
American Physical Therapy Association
American Society of Electroencephalographic Technologists
American Society of Medical Technologists
American Society of Radiologic Technologists
American Speech and Hearing Association
National Association for Practical Nurse Education and Service
National Association of Social Workers
National Environmental Health Association
National League for Nursing

American Board for Certification in Orthotics and Prosthetics
American Board of Registration of Electroencephalographic Technologists
American Intersociety Academy for Certification of Sanitarians
American Orthoptic Council
American Registry of Inhalation Therapists
American Registry of Radiologic Technologists
Association of Operating Room Technicians (Certification Board)
Board of Registry of Medical Technologists
(American Society of Clinical Pathologists)
National Board for Certification in Dental Laboratory Technology

American Association of Medical Clinics
American Dental Association, Council on Dental Education
American Hospital Association, Bureau of Manpower and Education
American Medical Association, Division of Medical Education
Department of Allied Medical Professions and Services
American Medical Association, Division of Medical Practice
Department of Health Manpower
American Nursing Home Association
Association of Schools of Allied Health Professions
Council on Associate Degree and Certificate Programs
Council on Baccalaureate and Higher Degree Programs
Council on Clinical Facilities
Council on Health Organizations
National Health Council

U.S. Department of Health, Education, and Welfare
 Office of Secretary
 Public Health Service
 National Institutes of Health
 Office of Director
 Bureau of Health Manpower Education
 Office of Director
 Division of Allied Health Manpower
 Division of Dental Health
 Division of Nursing
 Health Services and Mental Health Administration
 Community Health Service
 National Center for Health Services Research and Development
 National Institute of Mental Health
 Regional Medical Programs Service
 Office of Education
 Bureau of Adult, Vocational and Technical Education
 Bureau of Higher Education
 Social and Rehabilitation Service
 Office of Manpower Development and Training

 U.S. Civil Service Commission
 Bureau of Policies and Standards
 U.S. Department of Defense
 Bureau of Medicine and Surgery
 U.S. Department of Labor
 Manpower Administration
 Office of Economic Opportunity
 Office of Health Affairs
 Veterans Administration
 Department of Medicine and Surgery

CONFERENCE PROGRAM

Tuesday, September 7, 1971

- 4-6 p.m. Registration
- 6:30 p.m. Conference Dinner
Greetings and Introduction
Roma E. Brown, Research Director for Contract
Opening Address: "The Health Care System in Society"
Max W. Fine, Executive Director
Committee for National Health Insurance
- 8:30 p.m. "Meet Your Colleagues" Hour

Wednesday, September 8, 1971

- 8:45 a.m. Conference Perspectives
Robert J. Atwell, M.D., President
Association of Schools of Allied Health Professions
- 9:00 a.m. Keynote Address: "Certification for Allied Health Manpower"
Thomas D. Hatch, L.H.D.
Director
Division of Allied Health Manpower
Bureau of Health Manpower Education
Department of Health, Education, and Welfare
- 9:30 a.m. Symposium: "Allied Health Manpower in a Changing Health Care System"
Moderator: Edmund J. McTernan, M.P.H.
Dean, School of Allied Health Professions
State University of New York at Stony Brook
- Speakers: Conrad E. A. Herr, M.D.
Associate Professor of Social Science and Public Health
School of Public Health and Administrative Medicine
Columbia University
Francis C. Coleman, M.D.
Vice Chairman, AMA Council on Health Manpower
Harley Flack, Ph.D.
Chairman, ASAHP Committee on Equal Representation in Allied Health
Edgar O. Mansfield, Dr. P.H.
AHA Special Committee on Licensure of Health Personnel
Joanne Ross, Consultant
Social Science and Community Development

- 11:00 a.m. Dialogue Panel with Symposium Participants
- 1:30 p.m. "Interrelationship of Accreditation, Certification, and Licensure"
William K. Selden, Litt.D., LL.D.
Director, Study of Accreditation of Selected
Health Education Programs
- 2:00 p.m. Task Group Orientation
Roma E. Brown
- 2:45 p.m. Task Group Discussions

Thursday, September 9, 1971

- 8:45 a.m. Task Group Discussions
- 1:30 p.m. Task Group Discussions
- 6:30 p.m. Conference Dinner
Address: "Health Manpower From the Federal Viewpoint"
Merlin K. DuVal, M.D.
Assistant Secretary for Health and Scientific Affairs
Department of Health, Education, and Welfare

Friday, September 10, 1971

- 8:45 a.m. Task Group Discussions
- 1:30 p.m. Plenary Session
- 3:00 p.m. Adjournment

CONFERENCE OBJECTIVES

Through an increased understanding of certification in the allied health professions, the purpose of the Conference is to determine the need and feasibility for a future study of certification.

In this context the participants are:

- To identify the interrelationship of certification/licensure/accreditation in the allied health professions.
- To describe current practices and consider their advantages and disadvantages in light of public and professional needs.
- To consider the purposes and effectiveness of certification in the allied health professions.
- To identify general principles and policies used in the development and application of certification standards.
- To explore methods for increasing efficiency and economy in the certification process.

If conference participants recommend that a study be conducted, then the following factors should be delineated at the Conference:

Scope, objectives, priorities, procedures for a study and means for achieving cooperation of the professions.

TASK GROUP TOPICS

Current Credentialing Practices

- Describe, discuss and evaluate current credentialing processes including consideration of:
 - Reasons for selection of the process utilized;
 - Internal and external controls and influences;
 - Responsibility, authority and accountability.

Purposes and Effectiveness

- Discuss purposes in credentialing processes for allied health personnel:
 - Common purposes among the professions—present and potential;
 - Unique purposes of individual professions;
 - Effectiveness in achieving purposes of the credentialing process.
- Considering that current and projected health delivery systems call for changes in the role and relationship of allied health professions, discuss:
 - The effect of certification on practitioners' accountability and liability;
 - Certification as a force in protecting the consumer, the practitioner and the employer.

Social and Economic Implications

- Identify the effects of certification on:
 - Practicing in the profession;
 - Placement in a collective bargaining unit;
 - Job and economic security.

Principles and Standards

- Explore the legal implications of certification and professional association membership as mutually dependent components.
- Discuss and evaluate the reciprocal effect of changing roles of health care personnel and current certification processes.
 - Consider the impact of changing job function on certification;
 - Enumerate current uses and misuses of certification;
 - Project any additional uses of certification that would respond to the needs of the consumer, the professions and the health care system.
- Identify general principles used in the development and application of certification standards, and consider:
 - Levels or special categories of competency;
 - Standards as related to knowledge and skills required for job performance;
 - Alternative methods of achieving certification;
 - Revalidation of continuing competency;
 - Validation of competency for expanded roles.

Administrative Processes

- Review the general policies of certification in the professions and identify commonalities.
- Explore more economical and efficient means of developing and administering the certification instruments and processes.
- Discuss the pros and cons of sharing resources in the certification procedure.

Conference Recommendations

- Develop recommendations relative to a proposed study of certification in the allied health professions.

CHAPTER II—CONFERENCE PRESENTATIONS

Introduction	Roma E. Brown
The Health Care System in Society ..	Max W. Fine
Conference Perspectives	Robert J. Atwell, M.D.
Certification in Relation to Allied Health Manpower	Thomas D. Hatch, L.H.D.
Allied Health Manpower in a Changing Health Care System:	
Introduction	Edmund J. McTernan, M.P.H.
Professions, Professionalization, and Certification	Conrad E. A. Herr, M.D.
Transcendence of Certification Towards Equal Representa- tion in Allied Health	Harley E. Flack, Ph.D.
How a Health Care Adminis- trator Looks at Certification of Allied Health Personnel ...	E. O. Mansfield, Dr. P.H.
AMA Activities in Credential- ing of Allied Health Personnel	Francis C. Coleman, M.D.
The Consumer Views Allied Health Manpower	Joanne Ross
(No text submitted.)	
The Interrelationship of Accredi- tation, Certification, and Licensure.	William K. Selden, Litt.D., LL.D.
Allied Health Manpower From the Federal Viewpoint	Merlin K. DuVal, M.D.

INTRODUCTION

Roma E. Brown *

It is my pleasure to welcome you to this Invitational Conference on Certification in Allied Health Professions—and, to introduce you to the conference and your role for the next three days. We have challenging and important work ahead. Utilizing our knowledge and experience of today, as well as that of the past, we must perceive the needs for the future. The importance of the three days ahead is evident when one reviews the many forces and actions in motion today.

Perhaps the place to begin, in outlining the conference, is to briefly review the evolution of the conference. For several years numerous individuals—in both public forums and publications—have analyzed, perceived concepts, and projected recommendations relating to credentialing of allied health professionals. Our professions were relatively unidentified as a group until the term “allied health” was coined—a term which has undergone many variations in definition. Now, allied health—however it may be defined—has become almost a household term in discussions and publications addressing themselves to the solution of our health care problem.

There have been extensive comments on the various components of the credentialing system—its purpose, effectiveness, policies, standards—and the process of implementation. The interrelation and effect of many of these factors on the educational process was a subject of discussion in the Council on Health Organizations in November 1970 during the Annual Meeting of ASAHP. Also, at that meeting Dr. William Selden stressed the relationship of certification and licensure to the Study of Accreditation of Selected Health Educational Programs which was at that time in the process of being activated. Thus, the Council on Health Organizations initiated their consideration of the subject which has led to this Conference.

In November of last year both AMA and the AHA, respectively, issued position statements on the subject of licensure of allied health occupations including comments relating to certification. The Social Security Amendments of 1970—introduced but not passed—contained significant indicators relating to the subject. In President Nixon's message in late January, allied health manpower was again cited as a major resource to better serve the health needs of our country.

Contracts were made in January of this year to further explore the discussion initiated at the Council session of the Annual Meeting. One contact was with Mr. Thomas Hatch, Acting Director of the Division of Allied Health Manpower, N.I.H., DHEW, to inquire what interest or concerns the Division might have if an activity was initiated by the Council in this area. His interest was overwhelming, and resulted in his offer to consider support of our activity through funding an Invitational Conference. The Steering Committee of the Council approved a basic structure for a proposal for an Invitational Conference in mid-February which was finalized and ready for funding in early May. The contract for the conference was awarded to ASAHP in mid-June and thus preparations for this conference began. Close communications were maintained with the leadership of the Coalition of

Independent Health Professions, and progress communications were sent to the Council's allied health professions member organizations.

Concomitant with these efforts to obtain the opportunity for an Invitational Conference of the Allied Health Professions on Certification, numerous other activities were also in progress:

- The AMA and AHA convened a conference on February 19th to discuss a future course of action built upon the position statements of these two organizations. Subsequent to that conference, the AMA and AHA developed a draft proposal for a study of the credentialing mechanisms in the allied health occupations which, to date, has undergone three revisions.

- The National Health Form on "Health Manpower: Adapting in the Seventies" health in mid-March, featured certification as a major subject of the Forum.

- The Department of Health, Education, and Welfare convened a conference in mid-May to solicit information and views from the various organizations relating to the matter of licensure and related issues on which the Secretary subsequently reported to Congress in July, 1971.

- Congressmen introduced a multitude of health bills, including National Health Insurance proposals, which have significance on the subject of this conference. Our dinner speaker will provide further insight into this subject of National Health Insurance.

- The AMA Council on Health Manpower and the Council on Medical Education are preparing a statement on education and utilization of allied health manpower with reference to action in the area of our conference subject. This draft statement is currently being reviewed by the Panel of Consultants to the AMA Advisory Committee on Allied Health Professions and Services.

Thus the concern and interest in the credentialing systems for the allied health professions is evident.

This, then, is the background and climate surrounding our conference. The great confidence exhibited by the Division of Allied Health Manpower to fund the conference in light of all the concomitant activity is most significant and gratefully appreciated. You, representing the professions, have the opportunity to evaluate the current expressions and calls for action—admittedly some emotional in nature, some unsupported by facts, but some realistic and deserving of your most thoughtful and objective deliberation. Individuals from associations and federal agencies were invited to participate in this conference to contribute a wide range of perspectives. The selection of the general session and evening speakers and the content of the Source Book further extend the philosophy of bringing all views and concerns into the focus of the conference as a backdrop for your deliberations in the Task Groups.

The national associations that were invited to select representatives for this conference represent a manpower working force of over two million in the health care industry, of which nursing constitutes about one-half of that figure. Thus, the onus on you in these deliberations is great. The recommendations from this conference will indeed be tested, and will compete with other recommendations for future action.

Concrete solutions will not be derived at this conference—the scope and complexity does not enable us to achieve this. However, if through these deliberations there emanates a clear indication of a course of action and a basic philosophy and attitude, I am confident that your efforts will have a significant impact on the

future activity in the area of credentialing of allied health personnel. Coordination, permeability, unity, and mutual understanding, are some of the spinoffs that can be achieved from this conference. These will have the potential of carrying through into many other common interests and activities among our professions. Again, we welcome you to your challenge for the future. Your participation in the conference is valued and appreciated—may it be rewarding.

I would like to introduce and commend to you an outstanding group that has planned this conference—the Planning Committee: Robert Bartlett, Diane McCain, Edmund McTernan, Joanne MacDonald, Elaine Patrikas, Frederick Spahr, and Marjorie Tolan. It has been exciting to work with this group—a group representative of the many types of allied health professions. They are a wonderful team and I express my deepest gratitude to them and commend them to the conference participants.

THE HEALTH CARE SYSTEM IN SOCIETY

Max W. Fine *

I have been asked to bring the good wishes of the Committee of 100 to this important conference on Certification in Allied Health Professions. We thank you for the honor of participation in these meetings. I myself come with no professional credentials in the field of health care—but rather as a spokesman for a group of Americans who are deeply concerned with the crucial problem of how our free society can best meet its health care needs.

We are encouraged that you as health care professionals are willing to devote such an important block of time to listen to a consumer's viewpoint—such an ecumenical spirit is a refreshing development.

I have come to talk with you this evening about what many people believe to be a deep and growing concern among Americans with the crisis in health care delivery. But first, I want to discuss some broader problems, because we cannot solve the crisis in health care in a vacuum. We must find the answers to this problem within the broad framework of dealing with other very real and very urgent human and social problems.

We live at a time of revolutionary change and challenge. This is indeed a time of testing for free men, for our free institutions and for our commitment to the basic values of a free society.

We see a growing moral and cultural lag between our phenomenal progress in the physical sciences—in the art of working with material, with machines, with things, and our failure to make comparable progress in the human and social sciences, in the art of working with man. It is the growing gap created by our fantastic acceleration of scientific and technological know-how and our lack of comparable human and social know-why that feeds the deepening crisis in our world.

This is the first time in the history of man when we are capable of mastering our physical environment. This is the first time that the tools of production are

adequate to satisfy man's economic and materials needs and enable us to build a just social order in which we can facilitate man's growth as a social, cultural and spiritual being.

Our basic dilemma is that we have not fully comprehended the dimensions of the technological revolution. More than 90% of all the scientists who have lived throughout the history of the world are alive today and their creative and productive minds are unlocking the mysteries of the universe. We will make more technological progress in the next 25 years than we made in the last 2,500 years. But the question is: to what purpose do we commit this fantastic scientific and technological progress—to what purpose do we commit the power and the potential of the 20th century revolution?

The problem is not science and technology, the problem is man. Science and technology are neutral in the affairs of man; they have no ideology and no morality. We must work to bend science and technology to man's purposes. We must give them social direction and human purpose.

The dilemma of the human community is that science and technology have expanded man's wealth but not his wisdom. Science and technology have multiplied man's power but not his understanding, nor his compassion, nor his sense of community, when these qualities may be the key to survival.

The United States desperately needs to reorder its social priorities—we must give a higher priority to the real needs of people and not continue our prodigal waste of resources and human potential. As we approach the 200th anniversary of the birth of our republic, we are faced with greater instability than at any other time in those 200 years. The affluent and advantaged are calling for order; the poor and the disadvantaged are crying for justice. Unless we achieve both, we shall achieve neither.

Nor can we solve today's problems with yesterday's obsolete concepts—whether those concepts are "trickle-down economics" to revive a sagging economy or a prescription of "more of the same" to cure an ailing health care system.

It is within this broad context that we should look upon the crisis in the field of health care. It is not that we lack the scientific knowledge or medical competence—the broad cross-section of specialties represented at this conference is testimony to the astounding explosion of knowledge and skills that have been developed in the last 20 years. It is not because we lack the resources—we are already spending more money for health care than any nation in the world, now in excess of 7% of our GNP. We are in trouble on the health care front because we rely on a disorganized medical system and on an insurance industry that stands firmly in the way of developing a modern, rational health care system.

How did we develop this dysfunctional system which adequately serves neither the providers nor the consumers of health services? I believe that it grew up in response to deeply engrained myths, to irrational assumptions about reality. And like most superstitious behavior, it is tenacious and deeply rooted. What are the "American health care myths" that created our present chaos?

- The first, and perhaps most widely popular myth is that *public* or common financing of health services is socialism, or certainly at the very least, the first step on the road to socialism, and as such is to be avoided even at the cost of considerable human suffering. It requires considerable mental gymnastics to explain why the public financing of education is considered one of our democracy's finest achievements, and the similar financing of health services would be socialism.

Because social insurance—the most logical path to meeting unpredictable health costs—was blocked, those individuals and groups with sufficient financial resources went to the marketplace, thus gradually creating our mammoth private health insurance industry. Those without resources remained at the mercy of fortune. Never mind that the private health insurance industry has failed to achieve universal coverage and failed to deliver the health care or protection legitimately expected by those who purchased it. At least, according to the myth, it is not socialism.

As the gaps and inadequacies of the private health insurance system have been increasingly obvious, we have devised ever more complicated programs to shore it up and patch it together. Even with these efforts, the relentless increase of insurance rates and relative decline of coverage are clear indications that the creaky structure is going to collapse of its own weight.

- The second myth, which is perhaps most prevalent among health care professionals, is that *organization* and *delivery* of health services are one and the same thing. Academic institutions have managed to allow public policy makers and administrators to organize schools and still at the same time retain academic freedom within the classroom. But in the health care field we have enshrined the myth that if economists, consumers, planners, or administrators organize health services for efficiency and consumer convenience, they will inevitably interfere between doctor and patient in the delivery of those services. As a result, we have developed what President Nixon calls a "cottage industry" in which the medical profession attempts—with gross inefficiency—to preside over both the organization and delivery of health care services; and to decide, unilaterally, how much consumers will pay for services, who gets paid, and under what conditions payment is to be made.

- The third myth which has distorted our health care system is the mystique of *professionalism* which shrouds the delivery of many health services in secrecy. Like a medieval guild the medical profession has arbitrarily determined that certain procedures can be performed only by a physician—not on the basis of unique skill involved, but purely on the basis of tradition. This restrictive attitude has stifled the development of new health professions and discouraged the growth of teamwork in the delivery of services. The same myth of exclusive professionalism, or "peer review only" has been used to prevent outside scrutiny of the quality of health care. The result is a health care system in which the quality of care is extremely uneven and often the only recourse of the injured consumer is an expensive and difficult malpractice suit.

- The fourth, and final, myth which has shaped the development of our health care system is the *market economy myth*. Ignoring for a moment recent evidence that supply and demand traditions do not always work in the economy as a whole, I would suggest that they work least well—or not at all—in the area of health services. In order for a market economy to function, the consumer must have control over his expenditures. He must have a choice among suppliers of services, and he must have the requisite knowledge to evaluate the product's quality. Supply must be free to expand and meet demand, and there must be competition among providers. Yet none of these prerequisites hold true in the health care arena.

Most health expenditures are involuntary—the patient has very little control over which course of treatment the physician will prescribe, which hospital he will enter. The average patient has no basis upon which to evaluate the quality of care he receives. The supply of health providers is severely restricted, and in this captive

market of artificial shortage, there is no competition among providers. This has resulted in health care inflation at twice the general rate of the CPI. And yet, we as a nation have been convinced that reliance on the market economy will eventually produce a just balance of supply and demand of services at the most reasonable price.

Forces of Change

The interplay of these myths has created the health care system we now, almost universally, view as "in crisis". Even President Nixon has admitted that the whole unwieldy structure is on the verge of collapse. The question now becomes, do we sweep away these "myths" which have so distorted our health care system and build for the future on a solid new foundation—or do we attempt to piece together another unsatisfactory system based upon the tired old dogmas of the past.

I believe that there are at least three important forces at work which will push the country toward substantial reform of the health care system.

- The first of these is *inflation*. As I mentioned earlier, the costs of health services have been escalating at more than twice the general rate of other goods and services which compose the consumer price index. The burden of this imposes both on the consumer through insurance premiums and out of pocket expenses and on the government through Medicare and Medicaid is becoming politically unacceptable. The current wage-price freeze is proof that even a fiscally conservative administration cannot long tolerate runaway inflation. Because the incestuous network of powerful provider oligarchies—hospitals, insurance companies, organized medicine—cannot and will not control costs, alternative arrangements will have to be developed.

- A second important new force is the explosion of knowledge in the health care field and the resulting increase in providing services through *teamwork*. Appropriate use of the full range of medical and allied health professions can come about best through organized systems of health care delivery—call them pre-paid group practice, health maintenance organizations, comprehensive health service organizations or whatever. As consumers learn to demand comprehensive health care, as we develop improved programs to reach out into the community, and as we are forced for economy reasons to make better use of all our resources, the traditional feudal system of "solo fee for service" medicine will diminish. Is the sacred doctor-patient relationship sanctified by the exchange of dollars at the time care is delivered? We think not.

- Thirdly, I believe that the health care system will be forced to stop and take notice of the consumer. His preferences, convenience, and interests have been casually ignored for far too long.

The consumer is going to demand a meaningful role in determining where, how, and under what conditions health services are provided.

He is going to demand assurance that the care he receives is of high quality and that the enormous amount of money pumped into the health care system is wisely spent.

The crisis in health care came, like Carl Sandburg's fog, on little cat feet. But it is upon us now like a storm that threatens to break with unprecedented fury. At the moment we face two severe challenges. The first is a long-term one—shaping our nation's health care structure so that good care is kept within financial limits for all people, and is available to all. The second challenge is a short-term one—bringing health care to disadvantaged members of society. I do not restrict

my comments to urban health problems; as you know we are faced with an equally critical situation in rural America.

We must face both challenges simultaneously. We must remake the structure of our health care to benefit those who are within it, and at the same time expand that structure to serve those who are outside. And we must do both jobs without impairment of the quality of care.

Health care must be a matter of right, not privilege. Our goal must be one system for all. Even with the best of intentions, any system designed exclusively for the poor becomes a poor service. Everyone must be entitled to care regardless of race, income, sex, age, religion or any of the barriers that now create inequalities.

If we are to achieve our goals, health insurance must be removed from the profit-making arena. Comprehensive services should be equitably financed through social insurance and governmental general revenues. Health insurance systems controlled by corporations concerned with profit and power, rather than the people's needs, have shaped the collapsing structure we now have. We should drop them from the health field forever.

To develop a national system for the delivery of health care, it is necessary to give higher priority to health in our overall national goals. The Committee for National Health Insurance believes in the establishment of a multi-billion dollar Resources Development Fund—reserved exclusively for developing more health manpower and facilities.

Our proposals lie in the legislative hopper alongside other bills. Most of the other bills called "national health insurance" provide just enough to keep consumers and voters mollified for a few more years. They would keep the special interests floating a little longer, far above the lowly individual suffering unit that makes up the reason for the health professions. But this audience is aware that the problems of the people who come to you or whom you serve will not be removed by pumping more money into the hands of insurance companies. The problems remain and they grow more critical, even as we face formidable barriers to their removal.

Although private health insurance covered over 175 million Americans last year, this extensive coverage met only about one-third of private expenditures for health care. Thus 30 million people had no private health insurance whatsoever, and the policies available to those covered failed to meet nearly two-thirds of their total health expenditures.

Private health insurance has failed Americans in other ways. By focusing almost exclusively on episodic sickness it cannot even be appropriately defined as "health" insurance. Benefits for ambulatory care, as opposed to costly in-hospital care, are de-emphasized, and benefits for preventive care are practically non-existent. The carriers have failed to support cost or quality controls. Their benefit programs are concerned solely with the exchange of dollars and the limitations of their liabilities, and not with the provision of health care services.

There are 1,800 private health insurance carriers with 1,800 separate and competing sales forces, with substantial advertising budgets, with duplicate administration, with hundreds of policy variations. Why do we need such a bewildering array of policies, all for the same services?

The granite prejudices of some to real reform in health will not ameliorate the problems. Nor will they change the fact that this nation will adopt some form of national health insurance within the next few years. As health professionals, you have a responsibility to make national health insurance work. In particular there is

a pressing need for your leadership in the assurance of quality services and quality controls. Certification, licensure and accreditation serve as the first line of defense of quality of care. But the standards and the methods of quality control need constant re-examination and, if found deficient, need to be improved. Moreover, recent events have clearly shown the need to strengthen the administration of the certification and accreditation processes, particularly as they apply to nursing homes and independent laboratories.

CONFERENCE PERSPECTIVES

Robert J. Atwell, M.D.*

I want to thank again the Council on Health Organizations and their Steering Committee for the fine job that they have done in the organization of this conference. It's hard to get very vocal and philosophical so early in the morning, but I do appreciate their efforts. Also, the Association of Schools of Allied Health Professions appreciates your attendance. We appreciate your interest, the time you were willing to give to come to this conference for the very timely consideration of certification. We're looking forward to a very productive session, the success or failure of which is in your hands. We are also indebted to Tom Hatch of the Division of Allied Health Manpower for making this conference possible. As has been said repeatedly, without that support and the efforts of Roma Brown and her Steering Committee, this could not have happened.

The importance of certification is apparent to all in this time of critical need in the health professions and in health manpower. It is critical because people complain of it often and loud; and there is a real need for relevant studies of the process effected. As you know, Dr. Selden is busily at work under a grant from Commonwealth Fund on the Study of Accreditation of Selected Health Educational Programs—a very timely study to help insure quality control of educational programs in the allied health professions. The American Medical Association and the American Hospital Association are working on a proposal for a study of licensure—the governmental approach to quality control of health professionals. This conference addresses itself to certification as a means of quality control by the health professions. I hope Dr. Hatch will speak to the recent report on licensure for the Secretary of HEW. With all of these activities in progress, the wisdom of the Council on Health Organizations and the Division of Allied Health Manpower in addressing itself to certification becomes even more apparent.

Allied health is a confusing term. Allied health is not a profession. Allied health is a concept—a concept of interaction and interrelationship at all levels. The Association focuses on one aspect of this interrelationship, education, but is interested in the development of allied health as a concept—the feeling that education is of common interest and concern to all of us and that better education and better patient care are mutually supportive. It is with this in mind that the Association of Schools of Allied Health Professions formed four councils: A

* President 1971, Association of Schools of Allied Health Professions.

Council on Baccalaureate and Higher Degree Programs encompassing primarily the university programs; a Council on Associate Degree and Certificate Programs encompassing the community college programs; a Council on Clinical Facilities made up of hospitals as the location of many programs in allied health and as the clinical laboratories for most; and the Council on Health Organizations with membership as the name implies. Attendance at this conference is made up of representatives of the twenty-one professional organizations with membership in the latter Council, along with representatives of their certifying bodies, and also other selected invitees. It is our hope that this body will provide a mechanism for interaction, communication, cooperation, and—above all—a mechanism to understand the commonality of our problems and a mechanism to start solving some of these problems. We have many concerns which we can solve much better together than we can separately.

Certification is a common concern as attested to by your presence here. This conference is just a beginning; let us make it a good one and go on from here. You have the ball now and I'm sure you're not going to fumble it.

CERTIFICATION IN RELATION TO ALLIED HEALTH MANPOWER

Thomas D. Hatch, L.H.D.*

Welcome to the Invitational Conference on Certification in Allied Health Professions. It is my hope that this will be landmark occasion for the allied health professions. I have been anxious for some time to have a part in bringing together representatives of organizations that have interests in the credentialing of personnel in the allied health professions, to confront honestly some of the educational and professional recognition barriers that are affecting the production and utilization of allied health manpower.

Perhaps you are wondering why we in the Bureau of Health Manpower Education, an agency primarily concerned with education and the production of health personnel, should be concerned about the certification process. There are several reasons: first, we are concerned with the supply of health manpower; second, we are concerned about the stability of the workforce—retention, if you will; third, we are concerned about the quality of personnel in, and entering, practice. Certification relates to all of these problems. It relates to supply by controlling entrance into practice, it relates to retention by effecting mobility, and it relates to quality by providing standards for measurement of competency.

Clearly, certification and other credentialing practices do not now operate to their optimum potential in addressing these problems. I am, therefore, pleased that the Association of Schools of Allied Health Professions has undertaken this conference to discuss common objectives and problems in certification of allied health personnel. I am delighted that you were able to accept the Association's invitation to participate.

We do not need to discuss the health manpower problems that have been spurred in recent years by public demands for health services. We need only to keep in mind that the demands will increase exponentially. National health insurance is now visible on the horizon. I do not believe that we have begun to perceive the impact on the shape of manpower that will be needed to provide the services that such a program will require. If we are to meet the need when it is upon us, we must make some major changes in current education and employment practices of health personnel.

The credentialing of health personnel has a direct bearing on health manpower. There are essentially two types of credentialing. One recognizes the competence of educational programs to prepare personnel. The second recognizes the competence of individuals to deliver services. The first is generally referred to as accreditation, the second includes the practices of certification, registration or association membership, and licensure.

We are here to address ourselves to practices of certification in the allied health professions and their particular impact on the supply and the quality of allied health professions personnel. Although I know that each of you has special expertise in the area of certification, I feel that as we embark on this conference we all need to look at the development of existing practices from a broad vantage point to understand fully the framework in which we will be working during the next two days.

The recognition of individual competence—in this case, certification—is usually the responsibility of professional associations. The practices adopted by these organizations are intended to exclude the unqualified. At the same time, however, they have the effect of limiting competition in the work force.

In the allied health field, some of the professional associations are more than 50 years old. The American Dietetic Association and the American Occupational Therapy Association were established prior to 1920. During the 20's, five new allied health occupations' associations were formed, and in the 30's and 40's three additional ones were initiated. Today, the number of associations is nearly equal to the number of health occupations. In many cases specialties and subspecialties within occupational fields also have their own professional associations.

To become a member of a professional association implies having met certain standards for admission. These requirements include qualifications of education and/or experience.

In addition to the proliferation of associations professing the status of their members, for some professions there are committees, boards, or registries concerned with distinguishing quality of personnel. The certifying function may be within the professional association, as in the case of dietitians, medical record librarians, occupational therapists, and dental assistants. Or there may be agencies set up independent of, but obviously related to, the profession being controlled; examples are the Board of Registry of Medical Technologists of the American Society of Clinical Pathologists, American Registry of Inhalation Therapists (sponsored by physicians and inhalation therapists), and the American Registry of Radiologic Technologists (sponsored by physicians and radiologic technologists).

Persons who meet certain requirements of education, experience, and competency and who successfully complete the examination given by the certifying agency may use special professional designations and their names may be published by the registry or by the professional association.

Applicants for certification in nearly all health occupational categories are required to pass an examination given by the registry. The proportion that passes varies considerably from one field to another. For example, at least 90 percent of the dietitians, medical record librarians, and medical record technicians who took registry examinations last year were successful, but only 70 percent of the radiologic technologist candidates. These examination results include persons taking the test for the first time and those repeating for the second time or more. The passing point on the curve is usually determined in relation to first-timers and is set each time by the agency administering the examination, to permit only a certain percentage (usually between the 7th and 9th percentile) to pass.

Membership in the professional association is the second standard for certification. When the registry is a part of the professional association, it is usual to require that the applicant be a member of the association at the time of the registry examination. When the registry is a separate agency, even though the professional association is one of its sponsors, membership in the association may not be necessary.

Education and experience together make up the third standard. Graduation from an approved program in the specific subject matter is a "must" in almost all cases. Recognition of experience, in lieu of successful completion of a formal program of study in an approved school, is rare.

Certification of *specialization* within the profession usually is the function of specialty boards, as in the case of medicine or veterinary medicine. To be a diplomate of a specialty board requires graduate education, a period of supervised experience, recognized competency, and the successful completion of an examination given by the board. Among the allied health professions and occupations, there is not much specialization in this sense. However, recognition of special fields is provided by the Board of Registry of Medical Technologists (ASCP), which certifies persons as technologists in blood banking, chemistry, microbiology, and nuclear medicine. Specialties recognized by The American Registry of Radiologic Technologists include the more generalized diagnostic X-ray technology, nuclear medicine technology using radioactive isotopes, and radiation therapy technology using radiation-producing devices. Whether technologists in blood banking, nuclear medicine, and radiation therapy are to function as specialists or are to be counted as separate occupational categories requires careful attention.

Each of the allied health categories has matured in a pattern which seems to lean toward the protection of self-interest. First, a national organization is established to represent its members whose professional interests are similar. Next, the national organization develops a mechanism to assure itself that the educational programs are in keeping with their perception of what new personnel will need to perform on the job. The next step is usually certification of individuals. Finally, licensure is pursued. The latter tends to become a mechanism which, once established, not only can legally limit the manpower available for employment, but can effectuate these limitations in fifty different ways.

This pattern is at varying stages of maturity among the allied health occupations and needs to be redirected. The importance attached to the need for allied health professions groups to set broad mutual goals for providing high quality health services, rather than solely narrow goals which perpetuate self interest, cannot be overemphasized. This is true not only for existing categories, but

especially so for emerging occupations. The emerging occupations have an opportunity to avoid the mistakes that other allied health occupational groups have made and now must correct.

There are two related areas in which some solutions to the Nation's needs for more health manpower lie. They are (1) the development and implementation of education equivalency and work proficiency examinations and (2) the more efficient organization of educational programs.

It is now generally agreed that to meet the manpower needs, we must improve the utilization of people already employed and we must find ways to employ men and women who are well-qualified but who are now discouraged or effectively excluded from the health manpower labor market by formal academic requirements. "Medics" returning to civilian life from Vietnam have brought this latter need to a focus. They are, however, only an example. The central problem is that employment in many allied health occupations leads to *cul-de-sac* which offers no adequate recompense for experience, intelligence, or energy.

Better utilization and retention of manpower already employed will depend largely upon the success of efforts to enhance career mobility, both vertically and horizontally. This can be accomplished only by removing as many artificial or unnecessary obstacles to advancement and change as possible, consistent with the maintenance of adequate professional standards of service. The success of these efforts may be enhanced by the availability, efficacy, and acceptance of equivalency and proficiency testing programs for health personnel.

Basic to the concept of career mobility is the need to evaluate each individual's present abilities, regardless of the route he traveled to attain them. The goal of such evaluation is to encourage the advancement of personnel to levels of responsibility commensurate with their knowledge and skills. Proficiency and equivalency testing programs can serve as a basis for this evaluation.

Proficiency testing assesses an individual's technical knowledge and skills related to the performance requirements of a specific job. Equivalency testing evaluates knowledge acquired through alternate learning experience as a substitute for established academic requirements. There is no reason why such mechanisms cannot be incorporated into systems of accreditation and certification.

The second serious roadblock to increasing the availability of allied health manpower is the inefficient organization of existing educational programs.

Over the past 20 years, education for the allied health professions has been evolving from a system of primarily on-the-job apprentice training, to academically based educational programs through the doctoral level. This evolutionary process has been stimulated by advancements in scientific knowledge, public aspirations for higher education, and, I would like to think, the assumption by allied health personnel of more responsible and difficult functions and duties. More recently, it has also unquestionably been further stimulated by the fiscal constraints of service institutions—particularly hospitals, and the explosion of the junior/community college as an educational resource. The educational trend is desirable. It also gives rise, however, to questions as to the length of education required to carry out responsibilities at various levels, the appropriate and most efficient sequencing of academic and clinical training, and the articulation of educational programs at all levels.

There has been, more often than not, poor communication, cooperation and coordination among those who have responsibilities for planning and implementing training programs and those utilizing the trained personnel. This results in wasteful use of faculty, facilities, and equipment, all of which are in short supply and which must be utilized to their fullest extent. Education and training should also be better designed and organized to provide career options for allied health workers. Initial training should make it possible for an individual to work. It should also make it possible for him to use that initial training for academic credit if he is capable and chooses to prepare for higher level jobs in the same or related allied health fields. Likewise, his work experience should be considered for advanced standing in courses at higher training levels and employment at higher levels of responsibility. Health workers should not be cemented into dead-end jobs, but should have options for advancement which are individualized. Certification practices which rely on and relate closely to education and training must be channeled to encourage such opportunities for tomorrow's allied health manpower.

If, after hearing this summary of the certification process and some of its implications, you are confused, please join the club. I feel strongly, however, that certification has the potential of offering a vehicle through which entrance into allied health professions can be facilitated, that it can be a mechanism which can help to improve the retention of allied health personnel, and that at the same time it can be effective in helping to maintain a high quality of practice. The key, however, is that certification must be viewed, both conceptually and operationally, as a facilitator, rather than as an inhibitor.

To achieve this goal, it seems to me that there are a number of inherent requirements:

- First, certification standards should be developed nationally, so that they provide common standards and the maximum opportunity for geographic mobility.
- Second, the standards should be developed and coordinated in such a way as to provide the maximum degree of articulation among various levels within a professional field, and between occupational categories.
- Third, mechanisms must be developed and incorporated into the certification process which can be relied upon to measure competence, without regard to the ways in which skills and knowledge are attained.

As I indicated earlier, we have only begun to see the changes which public expectations and demands for health services will require with regard to the production and utilization of health manpower. To meet these challenges will require the cooperation and dedication of health professionals, planners, legislators, administrators. It will necessitate the development of an atmosphere of constant creative change—change that will test the personal and professional integrity of all individuals and organizations that have a role in the health of the American people. Each of you here today is participating in that creative process of change.

Credentialing practices are probably one of the hottest issues in health today. The challenge before you, it seems to me, is to find means by which to restore the credibility of certification as a measure of competency for the protection of the public, rather than—as it is now seen by many—a mechanism of self-interest and exclusion.

I am confident that this conference will be a milestone toward that end.

ALLIED HEALTH MANPOWER
IN A CHANGING HEALTH CARE SYSTEM
(SYMPOSIUM INTRODUCTION)
Edmund J. McTernan, M.P.H.*

The very dynamic Chairman of our Planning Committee, Miss Roma Brown, has provided to each participant in this conference a copy of the outstanding keynote address which was delivered last fall by Dr. Edmund D. Pellegrino at the annual convention of the Association of Schools of Allied Health Professions. In that address Dr. Pellegrino called for "the critical step of fostering the kind of interprofessional cooperation and exchange which is requisite for today's medical care." Our presence in this room today—in fact the entire purpose of this conference—is concerned with that kind of cooperation.

The past history of our several professional societies in allied health contains little evidence of the kind of cooperation which Dr. Pellegrino pointed out as essential for modern health care. In a way, we have resembled a lot of people penned up in a single room, each withdrawn and wrapped up in his own problems to the extent that each is almost unaware of the presence of the others. Indeed, we have been so concerned with our own needs, rights, and prerogatives that we have not only ignored our colleagues in related professions, but we have sometimes seemed to ignore the welfare of those we claim to serve. This conference is an opportunity for each of us to look across, to see, and to consider the problems of our colleagues in other allied health professions, as those problems relate to certification.

This conference has as its major goal the sharing of information among several of the allied health professions. From examination of the program you will see that the conference falls into two main divisions. The first phase is intended to provide to all participants general background information about certification procedures "across the board" in the allied health field.

The second phase amounts to what the World Health Organization would call an "expert panel" approach. Each participant in this conference represents an expert on a large panel, which will hopefully put together information and recommendations about what steps may be taken to improve the morass which is certification today—if, indeed, steps are indicated.

Our panel here today really represents that last part of phase one of our program—the end of the information giving portion. You will note that our panelists have not been chosen to represent any of the allied health professions *per se*, but that it has been assembled to contribute viewpoints from several points of the compass with which our professional groups should be concerned. One speaker represents the concerns of organized medicine as they relate to accreditation, certification, and licensure. Another is a spokesman from the point of view of the hospital, as a major employer of allied health personnel. A third represents a new form of health care delivery, the neighborhood and community health center. A fourth represents ERAH, the Committee on Equal Representation in Allied Health. The last is a spokesman for the consumers of our professional services. Each of our panelists has a difficult assignment ahead because we have asked them

* Symposium Moderator and Member of Conference Planning Committee.

to paint their position in broad brush strokes, yet within a time limit of fifteen minutes. I am sure that many of them have a message to bring to us far more important than can be adequately served in that brief time, but we do want to allow maximum time for interchange between panelists and conference participants. If we cannot cover the assignment within the time allotted to your satisfaction, I invite each of you to continue the discussion with us at ASAHP's fourth annual convention, which will take place in Atlanta on November 3-5, 1971.

PROFESSIONS, PROFESSIONALIZATION, AND CERTIFICATION

Conrad E. A. Herr, M.D.

It took me quite a while to fix this subject in perspective. I am a provider of health-related services. As a provider, I frequently arrange for services to be provided by persons other than myself to those consumers who contract with me. Some of those secondary providers are my employees; some are the employees of another provider, frequently a bureaucratically organized institution; and some are independent entrepreneurs.

To become a primary direct provider I underwent a specialized educational process in a bureaucratically organized institution. The educational curriculum was accredited by persons who had also undergone a similar specialized educational process—and by no one else. At the end of that specialized educational process, I underwent one year of specialized training in another bureaucratically organized institution. Again the curriculum was accredited by persons who had also undergone similar training—and no one else. The institution was accredited by a group of providers of health-related services—and no one else. A group of people who had undergone training and education similar to mine examined me and certified to the state government that I was qualified to be a provider of health-related services within the definition of my occupation as defined by the then members of that occupation. The state, upon receipt of a sum of money from me, granted me a license to do business.

After three more years of specialized education and training in programs accredited by diplomates of those same programs, I was examined by those same diplomates and certified as qualified in the advanced area of internal medicine. Along the way, I was examined by established members of my occupation to ascertain that I held the same values as all other members of my occupation. Having ascertained that I held the same values, I was recommended to and finally voted into membership in an association of persons engaged in my occupation. In other words, I was joining a profession. And it is the subject of profession, professionalism and professionalization that I want to explore with you. I want to suggest that certification of individuals is primarily a part of the social process called professionalization and that certification of individuals is used more to implement "occupational imperialism" (a term coined by Eliot Freidson) than to protect the health services client.

Professionalism appears to involve three sets of values. These values are expressed as beliefs and these beliefs dictate attitudes and these attitudes are implemented by behavior all of which serve to define an occupation as a profession and without which an occupation is not socially recognized as a profession. These value sets of professionalism are:

1. A belief in the commitment of the profession to the application of knowledge and skill for the unselfish benefit of mankind; and
2. A commitment to the occupation (profession) which itself defines and organizes the work. This includes concern with the prestige of the occupation and its position in the class structure, one indicator of which, in our society and in Russian society, is income; and
3. A belief in the definition of the work of the occupation as being:
 - 3.1 Extraordinarily complex,
 - 3.2 Nonroutine, and
 - 3.3 Requiring for its adequate performance:
 - 3.3.1. Extensive education and training, the scope of which can be determined only by the profession itself,
 - 3.3.2. Great intelligence,
 - 3.3.3. Great skill, and
 - 3.3.4. Highly complex judgement which, by the way, cannot be evaluated by any straightforward and definite rules, giving popularity to the "peer review."

A few years ago I addressed an audience of educators in the allied health field. I described a professional as a person who had the knowledge and understanding available in his occupation, who had the ability and skill to apply that knowledge, who had confidence in and self-assurance of his ability and who was committed to a value set and to an ethic which include adequate financial return but which extend beyond paycheck and job security. This is a simplistic definition which ignores the primeval human need for status and dominance so frighteningly described in *African Genesis*. It ignores the need for the occupational group to control the accreditation of the educational process, the certification of the qualification of the individual members, the organization of the work of the occupation, and the evaluation of the performance of the individual members. It ignores the apparent need of the occupational group to exclude others from the work of the occupation by a public and legal process, licensure, through which society accepts and acknowledges the exclusivity of the work of the occupational group to members of the occupational group as defined by the occupational group.

I hold to my simple definition and repeat that I want nothing but professionals on the same team with me. I want to work with no subprofessionals, no nonprofessionals, no paraprofessionals.

How does the primary care physician choose his employees? How does he select secondary direct care professionals for his patients? How does he choose institutions? How does he select indirect health services professionals? Whom does he recognize as professionals? Here the variables of accreditation, certification and licensure become such a jumble that I have difficulty understanding how this conference can focus on certification without considering the other variables. Before we explore the process let me first defend this approach. It is not that the physician makes so much money which bothers the health economists. It is the fact that the physician controls virtually the entire expenditure of health dollars. And it

is not the existence of physician professionalism which bothers social scientists philosophers like Eliot Freidson. It is the professional dominance in the health field which seems to be unhealthy. One quote from Freidson reveals the emotional depth of his conviction: "The medical profession exercises a degree of control over the delivery of health services that precludes both effective and adequate health care for the majority of the client population."

Since the physician is recognized as overly dominant in the health industry, I feel we are justified in viewing the utility of certification from the physician's vantage. As I have described, the physician himself has been certified, frequently doubly certified, and licensed. He opens a solo fee-for-service office. He hires a "girl" or recruits his wife to be receptionist, book-keeper, secretary and chaperon. Before long she has learned to do dip-stick urinalysis, micro-hematocrits, white count, electrocardiograms, chest X-rays and is giving dietary instructions to patients. Unless he is to do it himself, more complicated laboratory work must be sent out. Only if the laboratory studies are to be paid for by a third party does certification and licensure of the laboratory become the primary consideration for selection. Frequently, the mark-up, the difference between the going charge to the patient and the amount for which the lab will do the work, is the deciding factor. Of course, it may be politically important for the physician to send his lab work and his radiologic referrals to the private voluntary hospital whose staff he wishes to join.

Even after the practice has grown and the physician has been joined by several associates, recruitment of non-physician employees is often a personal and intimate procedure. One associate who is attending at the county hospital will suggest that they steal that hospital's night E.R. nurse. Where did she go to school? Is she an L.P.N. or an R.N.? Degree or diploma program? Who cares? She's good and the group's bureaucracy has not yet solidified. With the evolution from solo to group practice, the associates may decide to build a new or expand their space; rent out a piece to a pharmacy; add a part-time pathologist and open its own laboratory; add a part-time radiologist and a full-service diagnostic X-ray department. Although all of the standards for the group are internally set, the growing group cannot resist bureaucratic organization and the tendency away from generalists and toward the hiring of specialized nonphysician employees becomes a rule. A table of organization is drawn, job descriptions are written and job qualifications are defined. It is no longer economical or practical for one of the physicians to observe the work of a nurse or a technician or a dietitian before recruiting that individual for employment with the group. The group begins to look to more formal indicators of acceptability. Rarely is a licensure considered, for licensure of an individual is consideration only if licensure is necessary for the group to be able to collect fees for the services which that individual provides. The group, and this goes for non-profit groups and hospitals as well, looks to the interlocking system of accredited teaching programs, certification and registries to provide a degree of guarantee of individual competence.

I suggest that this system of accreditation, certification and registration is becoming so in-bred that it frequently is no more than part of the social process of professionalization and fails to guarantee individual competence. It certainly rarely guarantees continued individual competence. Our critics argue that it furthers the dehumanizing segmenting of health-related services, it reduces the flexibility of the delivery system, it resists innovation and it raises costs.

I suggest that this conference deal not with the social pressure of occupational groups to attain professional status but with the challenge to provide the best of modern health-related technology to all citizens of these states with public accountability for what we do. I suggest that the definitions and descriptions of the health professions as we now know them may all have to be redone and that the present hierarchical work organization may have to fall. I suggest that we approach the work of this conference with open self-awareness and good faith.

Certainly if we wish to impose our will on the public we need only to organize to do so; there are so many of us. *The Health Manpower Source Book 21* published in 1970 by DHEW using 1967 data enumerates at least 2 million persons in health-related occupations which meet many or most of the sociologic definitions of professions. A quick glance in the *New York Times Encyclopedic Almanac* for 1970 reveals that the Teamsters have only 1.6 million and the United Auto Workers have only 1.4 million members. I repeat that it would be easy for us to give the public what we want. I suggest we look for ways to give the public what it wants. I suggest we explore the problem of certification in relation to its ability to provide continuing protection to the public, its ability to provide accountability, its ability to allow flexibility in systems of delivery of health-related services and its ability to permit horizontal and vertical mobility for the health professional. I suggest that we weigh the value of the certification proposals which will be forwarded at this conference and honestly measure what's in them for or against the public versus what's in them for or against our several or individual occupational groups. I suggest that, unless our efforts result in a system which promotes public confidence, our entire effort will have little meaning and little relevance to a society which is increasingly describing our work as dehumanizing and a society which is becoming increasingly skeptical as to the degree which our effort has any necessary bearing at all on the technical outcome. I believe our critics will be watching this conference with great interest. Let us deliberate well.

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TRANSCENDENCE OF CERTIFICATION TOWARDS EQUAL REPRESENTATION IN ALLIED HEALTH

Harley E. Flack, Ph.D.*

The common purpose of us here today is an interest, a concern and a desire to transcend certification as we know it today. But to transcend is *not* to repudiate. "Transcendence is not superiority, but difference in quality: a new way of seeing, of living. . . according to new circumstances." (1) From these perspectives, I shall preface my remarks today.

New Circumstances

Historically, racism has militated against Blacks, Spanish-speaking, and Indians entering the main vein of our allied health system today. Projected allied health manpower needs in 1980 indicate the necessity for more allied health professionals. If we are to arrive at a distribution of black allied health professionals equal to their representation in the general population (about 15%), we will have to realize a 700 to 800% increase in the number of blacks recruited, retained, graduated and licensed in the allied health field.

Racism is in the process of (a) coming to our awareness and (b) being eradicated from within and without; from within, through education and training; from without, through an ever stronger pressure from public opinion and government. Yet, to speak of racism in education and training is to speak of accreditation and certification.

If our intent were to "get down on the case of" the mix of racism in certification and accreditation, we would find them "fatted calves." But our wish is to transcend and *not* to repudiate.

The entire process of certification can be analyzed via three variables, i.e., philosophy, structure and process. I will consider these contiguous variables in relationship to actualizing equal representation in allied health.

Philosophy

The purposes of certification reflect professional association membership philosophy. Regardless of the Association in question, two common purposes of certification defined in the recent HEW publication, Accreditation and Certification (2) are:

- Certification provides the worker with an orientation to his profession. Don Shields (3) reviewed the official policy position of 24 health care professional associations. Here are a few: ASHA "Racial, religious and sexual discrimination is inconsistent with the goals, purposes and policies of the association . . . All programs and activities of the association shall be carried out in a fashion so as to be consistent with this policy."

The AOTA submitted its standards for O.T. Service Programs (1969). A portion of this document reads, "excellence of O.T. will be measured by the depth, scope and quality of the services offered in relation to the fullest possible potential."

AMA—"The AMA recognizes that health is related to the components of education, housing, environment control, transportation, civil rights and alleviation of poverty. The AMA continues to show an active, innovative and constructive interest in these non-medical components (of health)."

These quotes demonstrate the spectrum of the degree of commitment and programming of professional associations to the health and manpower concerns of the poor, the black, the red, the poor white, and the indigent. Yet, a growing concern for consumer orientation is developing within professional associations. An example of this consumer orientation is reflected in new concepts related to accreditation. For example, a quote from a recent publication of the Federation of Regional Accreditation Commission for Higher Education is "direct public representation should be implemented with accreditation agencies." (4) Should similar consumer orientations be incorporated within the certification process?

- Certification gives a feeling to the professional that he is the best qualified. Many Blacks, Spanish-speaking and Indians may have the stigma of being "second best" to overcome as a result of having graduated from a "special allied health program" for the "disadvantaged." How do policy and philosophical pronouncements of associations address this issue?

Structure

Philosophies are inevitably translated into structures. That is to say, structures reflect the design of their architects. The structure of certification may determine:

- Quality of performance.
- The bodies which control
 - written exams
 - membership in associations
 - criteria for evaluating educational experiences.

Changing structures

The doors of professional associations are revolving, i.e., persons are constantly affiliating and disaffiliating with professional associations. However, cautions must temper our observations. That is, blacks and other minorities may be leaving or have left these associations because of inconsistency of personal and associational philosophy and practices related to specific allied health professional as well as general issues. However, persons who have taken leaves in this manner are not necessarily lacking in quality in their practice—but rather may be desirous of marching to the beat of different drummers.

How do associations perceive those black caucus groups who have left their association either physically or philosophically?

- Are they (caucuses) viewed as radicals?
- Are they viewed as threats to lowering high standards of the profession?
- What kind of communication and joint planning between black caucuses and associations exist?

We need to involve more Blacks, Spanish-speaking and Indians in decision-making positions concerned with certification. Viewing the absence of color in this group this morning, I charge each of you to insure racial mixtures within your respective associational committees and groups concerned with certification and

accreditation. Such persons will bring important perspectives and inputs to the certification process.

Processes of certification

Ultimately, the philosophy and the structure of an institution determine process. What processes in certification are likely to have significant impact and influence on the development of equal representation in allied health?

- **EXAMINATION**—Today we are experiencing such headlines as the following from the August 26 New York Times: "Black enrollment in universities rising higher than white."

The article points out that 6.6% of university enrollments are of black students. Some of us may respond, "Well, it's about time." Others respond, "Those black guys are getting everything. They don't have to take entrance exams; they get their tuition paid for and they do lower quality work yet still graduate."

With these perspectives on education of blacks, some professional associations may consider *not* obviating the necessity of examinations for certification of black professionals. That is, professional associations may view the written exam as maintaining the bastions of professionalism.

Another question that should be asked regarding certification and registration examinations is: Are they valid for Blacks and Spanish-speaking? What percentage of persons who fail these examinations are Black, Spanish-speaking or Indians? What happens to such persons who fail the exams? Are certification bodies capable of helping the "failures" qualify despite their failures?

- **PROFICIENCY CREDIT AND CERTIFICATION**—Last week I had the good fortune of talking with a black woman who lives in Buffalo's black ghetto. She has had *only* two years of college education. Yet her knowledge of human behavior and ghetto health and health problems and problem remediation would put many of our university and clinical experts to shame. Should such persons be permitted to acquire certification if they can demonstrate that they have gained this knowledge and experience? Would a written examination validate the knowledge, skill and proficiency in delivering services in the example I just used?
- **LINKAGES WITH ACCREDITATION**—I have tried to outline those activities which I feel accreditation should engage in in order to facilitate equal representation in our allied health manpower system. Those three essential activities were:
 - Expanding guidelines and criteria, e.g., I feel that "special programs" for "disadvantaged" should be accredited to insure sound background for disadvantaged students who desire to enter allied health careers.
 - Researching career mobility, educational curricular structure and processes which influence the entry of, retention, and graduation of Blacks, Spanish-speaking and Indians in allied health.
 - Monitoring the entire educational process as it affects Black, Spanish-speaking and Indian students and faculty representation.

Certification concerns within professional associations must be translated into changes in accreditation. That is, if there are to be more Black, Spanish-speaking and Indian allied health professionals to certify.

- **RECRUITMENT**—I am sure that we will experience tremendous movement in the next decade toward equal representation in allied health. To be sure, the distribution of Blacks, Spanish-speaking and Indian professionals will be a direct outcome of the degree of recruitment emphasis of professional associations. The implication for certification is this, what is to be reaped must be sown.

Affirmative action, certification and accreditation

The committee for Equal Representation in Allied Health is about to convene a congress of about 20 of the black caucuses of health professional associations. At this congress, certification and accreditation will certainly be an issue. One recommendation may be that each caucus should study the accreditation and certification processes in relationship to their respective associations. The congress will raise questions as to how professional associations are facilitating equal representation in the allied health professions. A joint study of accreditation and certification implemented by all the members of the congress may be proposed and carried.

The Committee for Equal Representation in Allied Health of the Association of Schools of Allied Health Professions proposal, when implemented, will have to determine the influence that accreditation and certification will exert on our programs. Preliminary observation suggests that the influence of these processes is great.

An Urban League program recently funded by NIH is concentrating on developing allied health programs in the predominantly black southern schools. Accreditation and certification have been influencing the development of allied health programs in the black southern institutions. Strategies are being developed to deal with these barriers.

Conclusion

The inter-relationships of the philosophy, structure and process of certification can have significant influence in our realizing equal representation in allied health. Consistency and commitment—a philosophy dedicated to public involvement at every level in certification and accreditation—is a necessary first step toward change. Structural changes insuring full participation by Blacks, Spanish-speaking and Indians in the total certification and accreditation processes must be the second step. Finally, many modifications in the processes of certification and accreditation are indicated if we are to transcend what has been. That is, what we hope to be must be who we are and what we do.

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HOW A HEALTH CARE ADMINISTRATOR LOOKS AT CERTIFICATION OF ALLIED HEALTH PERSONNEL

Edgar O. Mansfield, Dr. P.H.*

The health care administrator is vitally interested and deeply involved in the quantity and quality of allied health personnel. The administrator, however, is an organizational manager and is primarily concerned with the highest over-all performance of the organization at the lowest reasonable cost. Results, image and growth are the key areas of his thrust. Manpower, money and materials are the basic elements through which the goals of all organizations are sought and achieved. The effect of certification on quantity and quality of manpower, therefore, is at the core of the administrator's interest in certification.

Manpower

The great increase in the role of manpower in the health related services has been brought about by:

- Greater knowledge and higher expectations of the public in health matters.
- Major advances in the scientific, professional and technical aspects of health care.
- Population increase and economic affluence.
- Proliferation of health occupations.
- The high personal service aspects of health care.

Since quality service at the lowest reasonable cost is a major objective of the health care administrator, he must be really interested in manpower costs. He must attempt to have the right numbers of the right kinds of health personnel available at the right times. This is a major part of his total responsibility.

Key Questions Administrators Have About Certification of Allied Health Professions

- What effect does certification have on the number of health personnel in a given specialty field?
- Are the exclusion factors becoming more restrictive? (Professionalism, cult, jargonese, caste system, etc.)
- How can certification be compatible with maximum availability, promotability and mobility of personnel?
- Is certification any longer workable (or necessary) for protection of the public?
- What is the effect of certification on wages and salaries?
- What are the advantages or benefits of certification concerning personnel self-confidence and psychological plus values?
- What are the effects of certification on "over-qualifying" people in certain positions?
- Will continuation of certification lead to further segmenting and fractionalization of health care?
- Will the liability of health care institutions be further jeopardized by burgeoning certification?

- Is licensure the ultimate goal of groups seeking strong certification programs?
- How can voluntary certification satisfy the "public interest" responsibility?
- What answer to the question of "self-perpetuation and in-breeding" of certification bodies (owned and operated by the specialty group or health occupation) can be given?
- How can quality of performance be kept at an adequately high standard when payment of dues may be the only continuing requirement with some specialty groups?
- How can the "jurisdictional dispute problem" be dealt with as health care employers require maximum flexibility in hiring, training, transfer and promotion of personnel?
- Can certification keep up with rapidly changing job requirements in the health care system?
- How can overall supervision and controls be set up, on a voluntary basis, for all health care occupations?

Summary

In conclusion, health care administrators, while to some degree taking credentialing and certification of allied health personnel for granted, realize the many plus values that have accrued from certification. As the ratio of allied health personnel to physician increases, questions that require thought and action confront us. It is to the extent that the responsible allied health professions leadership can provide reasonable and workable answers to these questions that the future regulations of certification will remain in voluntary hands.

AMA ACTIVITIES IN CREDENTIALING OF ALLIED HEALTH PERSONNEL

Francis C. Coleman, M.D.*

I appreciate the opportunity to participate in this Conference, and to share with you some of the thoughts and activities of The American Medical Association in regard to credentialing mechanisms, or—more specifically—in regard to licensure and certification of allied health occupations.

A definition of terms is sometimes helpful at the beginning. Occupational *Licensure* commonly refers to those governmental processes by which permission to engage in a profession, occupation, business, or public service is granted to persons or legal entities whose activities affect the public health, safety or welfare. It is one of the tools of governmental policy and involves the establishment and enforcement of minimal standards and certain prohibitions for entering and remaining in the particular activity or calling subject to governmental regulation. Occupational licensure may be of two types (a) *Mandatory*, wherein only persons holding a license are permitted to practice the occupation, with unlicensed persons prohibited from working in the field; and (b) *Permissive*, wherein only persons holding a license are authorized to use a particular title or official designa-

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tion; unlicensed persons are not prohibited from working in this field, but they may not use the protected title.

The term *Accreditation* refers to non-governmental approval of education and training programs for a health occupation which meet the qualifications specified by the professional association for that occupation, sometimes in conjunction with other professional groups. For example: schools for the training of Radiologic Technologists are accredited by the AMA Council on Medical Education in collaboration with the American College of Radiology and the American Society of Radiologic Technologists.

Registration and Certification refer to non-governmental approval of personnel meeting qualifications specified by the professional association for that occupation. Such qualifications usually include completion of an accredited training program and successful performance in an examination administered by the professional group. For example: The American Registry of Radiologic Technologists investigates, examines and certifies the competency of Technologists applying for registration. In some states and for some occupations, licensure, accreditation and certification are interrelated to the extent that graduation from an accredited training program may be a prerequisite for eligibility to take a certification or a licensure examination, or—in a few instances only—that licensure may be granted without examination to individuals already certified by their professional association.

You can see that licensure, certification and accreditation are interrelated to an extent that makes it difficult to study any one process to the exclusion of others. Within AMA, the Council on Medical Education and its Advisory Committee on Allied Medical Professions and Services have responsibility for accrediting the educational programs of selected allied health occupations, in collaboration with the appropriate professional groups. The Council on Health Manpower, through its Committee on Certification, Registration and Licensure, which I chair, is concerned with the relationships between health personnel licensing, registration, or certification systems and the effective use of health manpower, and to modifications which may be needed in these systems to favorably alter the distribution of responsibilities between physicians, nurses, and allied health workers so that the quality of care is preserved while availability of services is significantly increased. Our committee has been particularly concerned with the tendency toward proliferation of licensing laws for specific groups of health professionals, both existing and emerging, which could tend to accelerate the fragmentation of health care services, and freeze health occupations into legislatively circumscribed service roles.

As you know, the limitations of licensing mechanisms for health occupations have already been extensively discussed and documented in the literature and in practice. They include possible obsolescence in this age of scientific and technological breakthrough and uniform standards of education, promotion of a "Craft Union" approach to health care and resulting increases in cost, inhibition of innovations in education and use of health manpower, and restrictions on career mobility. AMA's policy on licensure and certification in general is as follows:

"The medical profession believes that the adoption of a position on governmental (state) regulation which would apply permanently to all health related sciences, professions and services is not in the present nor future interest of the public. In relationship to this general principle, the medical profession believes that:

- The extension of governmental licensure and/or certification for scientific, professional and technical health personnel is not indicated except when it is mutually agreed that such regulation is necessary in the public interest and such regulation is jointly developed and supported by the medical profession and the segments of medicine concerned and the group seeking statutory regulation.
- If instances do arise in which it is jointly agreed that it is necessary in the public interest that governmental (state) licensure and/or certification be developed for persons in activities directly involving the care of patients:
 - Such statutes must require acceptable educational standards as determined by individuals acknowledged as leaders in education and practice in the field.
 - Such statutes relating to services which involve the diagnosis or treatment of nervous, mental or physical illnesses or disorders of individual patients should require such services to be performed under the direct supervision of or in genuine collaboration with a qualified physician."

With specific reference to the many new types of physician support occupations that have been generically termed "Physician's Assistants," we have been especially concerned with the potential dangers of premature licensing of such occupations, when their roles in health care have yet to be completely delineated. For this reason, AMA has adopted a position favoring certification of physician's assistants, and opposing licensing of these individuals by any state agency. In follow-up to this action, we are now exploring the possibility of developing a national program of certification for physician's assistants. Such a program would grant certification on the basis of validated proficiency testing to individuals of both traditional and unorthodox educational background, and will hopefully help to ensure orderly development of the physician's assistant concept under medical guidance.

The standards established by professional groups for certifying the competency of their members are set at a higher level than those for licensure and are designed to achieve excellence. These professional groups work to build curricula, accredit educational and training programs and establish their own disciplinary procedures to maintain professional standards. However, it is fair to say that voluntary certification mechanisms share some of the shortcomings of occupational licensure, including lack of routes to certification or registration other than through completion of formal education programs, and restriction of upward and lateral career mobility. Our Council on Health Manpower prepared a report adopted by the AMA House of Delegates in December 1970 which reviews some of the acknowledged limitations in both governmental and voluntary occupational credentialing mechanisms, examines some of the suggested changes or alternative approaches now under consideration or trial, and recommends steps designed to resolve known shortcomings in the system, including:

- A moratorium or holding action on state licensure of any additional health occupations, to permit time for study of suggested alternatives to the present system and development of a workable over-all approach to health occupations credentialing,
- Creation in cooperation with other national groups of a national study commission or task force to develop such long-range solutions,
- A number of steps to effect immediate, short-term alleviation of short-

comings in the present system including (1) the amendment where indicated of existing licensure laws to permit expanded function of task delegation and increased access to licensure or certification for those with other than traditional prerequisites, and (2) expansion of programs for periodically up-dating and maintaining competence.

We are now working with other national organizations to attempt to initiate the proposed national study commission, which would function independently, once established.

What *should* an ideal credentialing system be? Without "Second-Guessing" the conclusions of the study commission or of this conference, I think we would all agree that an acceptable regulatory mechanism for health occupations should incorporate at least some of the following characteristics:

- It should provide a generally accepted guarantee or attestation as to performance capability,
- It should provide a workable mechanism for *enforcing* compliance with agreed-upon standards,
- It should minimize the barring of applicants from practice in a profession on any basis other than professional qualifications,
- It should provide some practical mechanism for encouraging continued competence in the profession,
- It should serve as a symbol for professional recognition and peer group identification,
- It should be structured to recognize and credential health occupations on the basis not only of formal educational achievement, but of validated proficiency testing as well,
- It should minimize redundant or duplicative qualification procedures or tests,
- It should avoid specifying course content or duration of prerequisite educational experience,
- It should allow interstate mobility for the occupation credentialed,
- It should specifically allow for and recognize the legality of delegating part of the tasks of the credentialed occupation, with stipulated supervisory safeguards,
- And finally, it should define the scope of functions of the credentialed occupation in terms of broad service roles rather than specific tasks, with specificity only in terms of desirable supervision.

The challenge to all of us is to draft an approach or approaches that meet these important criteria.

THE INTERRELATIONSHIPS OF ACCREDITATION, CERTIFICATION, AND LICENSURE

William K. Selden, Litt.D., LL.D.*

You have invited me to speak at this conference on the interrelationships of accreditation, certification, and licensure. To these activities I am adding for your attention a fourth and related activity; that of registration.

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The theme of my remarks can be stated very explicitly. *Do not be parochial in your deliberations!* In other words, not only are accreditation, certification, licensure, and registration related to each other but they are part of a much larger picture than has usually been recognized.

In the health professions and in all walks of life we are subjected to many screening devices. These commence actually before we are conceived. Our biological heritage and the environment into which we are born exert profound influences on our future lives. Our formal and informal schooling; the types of tests we are given; the sensitivity and ability of our teachers; the types of schools to which we are assigned, or to which we are granted admission; the employment policies and practices to which we are subjected—all of these factors provide methods of selection. We should not overlook them when we consider the place of accreditation, certification, licensure, and registration.

These four activities are part of a series of selection mechanisms that have generally been considered as independent functions to be developed with little regard to each other or to the place each plays in the full gamut of screening operations. This is one example of the parochial tendencies that will be implied in the latter part of this paper.

Even though you may be given definitions of terms that you will be using, let me present those which we are presently employing in the Study of Accreditation of Selected Health Educational Programs, commonly known as SASHEP:

Accreditation is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study, or their services.

Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title, or grants permission to institutions to perform specified functions.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

As most of you already know and as these definitions attest, there is an intimate relationship among these four screening activities. In many states and in many professional fields, the award of a license is dependent, at least partially, on the individual having been graduated from an accredited program of study. In the case of certification or registration this requirement is even more prevalent.

Let us now consider briefly the issue of control. In the case of accreditation of health education programs, the control rests either solely with the respective profession or with the profession on a basis of collaboration with another profession. Accreditation requirements may be interpreted to require that the faculty members must, at least in most cases, be members of the profession. Licensure is conducted under a state board whose members are frequently not only members of the respective professions, but are proposed by the state professional society for nomination by the governor.

This interlocking or interrelated control grew naturally from the philosophy that only members of the profession, whatever the profession, are competent to

judge their future fellow members, that only in this manner could the public be provided some protection from inadequate and unscrupulous practitioners, and that only in this manner could the profession protect "the property right" which each member of the profession derived from the investment of his time, money, and energy in acquiring his or her special professional expertise to be a certified, licensed, or registered practitioner. The basic assumption for this type of control was that only the members of the profession knew what would be best for the profession and what would be best for society, and that they could best decide, if there ever should be a conflict between these two interests.

The very recent Report on Licensure and Related Health Personnel Credentialing from the Secretary of the Department of Health, Education, and Welfare to the United States Congress (June 1971) addressed itself directly to this factor of control:

"Only a few years ago, issues such as licensing, certification, and accreditation were generally thought to be the concern of only the professional individuals and organizations that were affected by them. The public policy aspects of these issues were not often perceived by decision-makers long accustomed to the guild traditions that have characterized attitudes in this area. Today, these matters are not immune from public criticism; and the responsibility of both public and private leadership is to fuse health-manpower credentialing with the public interest."

At this point we come to the question of public interest which is requiring all of us to look at the delivery of health care from new perspectives, regardless of how painful the process may be. I believe that this is basically why this conference has been convened and why the federal government has funded the project.

* * *

With this introduction I will now postulate a series of propositions and conclude with a number of questions to which this conference and possibly a future study should be giving consideration.

First, the propositions:

- The discoveries of medical science in the United States during the present century have been unequalled at any time by any other country.
- The quality of health care enjoyed by a limited proportion of the population of the United States has been surpassed in no other country.
- The development of medical science and the patterns of the delivery of health care in the United States have matured in a society who politico-economic structure was based on the entrepreneurial philosophy of laissez-faire and on the teachings of the Christian religion with its provision for charity patients.
- Concurrent with and to a large extent resulting from the growth in human population, the advances in science and technology, the improvements in communication and transportation, the industrialization of society, and the independence and nationalization of peoples on all continents—the world is undergoing a politico-economic revolution in which few elements of society are unaffected.
- The current world-wide revolution involves both a struggle among contending groups for economic and political power, a spreading spirit of

equality, and a reassessment of the structure and operation of government, as well as a reassessment of the philosophical concepts on which civil political structure has been based.

- Among the social benefits, for which groups are contending in the United States, is a more equitable provision of health care.
- The enfranchisement of large groups of individuals previously disenfranchised has coincided with greater involvement of government in cooperative planning for the delivery of health care and rapidly increasing public financing of health care.
- With greater involvement in and increasing financing of health care on the part of government, the question of public accountability looms as an issue of broad and fundamental import which can be resolved only within the context of the currently evolving socio-political transformations.
- Accreditation, certification, licensure, and registration were fashioned as part of the mechanism of social control of health professional personnel to meet the socio-political needs of an earlier period.
- In that earlier period public accountability was accepted slowly and unevenly as being vital to the welfare of society and has only recently been recognized to be as important for the entire field of health care as it is, for example, for the entire sphere of economic activity.

* * *

It is within this framework of these postulated propositions that a series of questions related to certification should be faced. The following set of questions comprises some of the questions with which this conference should be concerned.

- To what extent do accreditation, certification, licensure, and registration collectively and individually justify to society their continued existence?
- Assuming that their continued existence proves to be justified, and assuming that these activities were originally developed without full consideration of their potential complementary features, on what principles should they be modified to complement each other?
- On what principles should a professional field undertake or not undertake the functions of accreditation, certification, licensure, and/or registration?
- Who should establish and enforce these principles referred to in the previous two questions?

* * *

The following additional questions, which relate specifically to certification, might also be considered.

- Who should be responsible for the certification of the members of a health profession, and who should be involved in the process: members of the professions, members of related professions, representatives of employers, representatives of the public, government officials, etc.?
- What factors should be considered to qualify individuals for certification: previous enrollment in specific courses, graduation from an approved program of study, passing a test or tests, previous work experience, endorsement of certified practitioners, etc.?

- Should certification be granted for life or for a maximum stated term? If the latter, how long should be the term? And on what basis should renewal be granted: passing of a test or tests; enrollment in continuing education courses; endorsement of other certified practitioners, etc.?
- What benefits accrue to a profession that undertakes a program of certification? Can these benefits be obtained by pursuing some other method?
- What are the uses of certification? Are these uses compatible with the function of certification, or do they subvert certification by making it serve purposes for which it is not prepared or designed to serve?

There are other questions and issues which need to be considered with respect to certification. However, these are sufficient to indicate my observation that greater attention must be given in the future to the inter-relationship of accreditation, certification, licensure, and registration than has been the case in the past. In addition, I should add the comment that any review of certification should include *all* the health professions, both those which are already supporting this activity as well as those that are seeking to do so.

ALLIED HEALTH MANPOWER FROM THE FEDERAL VIEWPOINT Merlin K. DuVal, M.D.*

When I was a young physician just starting out in practice, there was really no formal grouping of health workers called the "Allied Health Professions". The scope of the allied health professions, their organizations, for that matter the size of the entire medical field were much smaller than they are today.

Employment in the health occupations and professions in 1940 was about 1 million people—one-fourth what it is today. And while the health field in general has been doubling and redoubling, the *allied* health field has been growing at an even more rapid pace. Today's allied health workers number more than 900,000 about the size of our entire health force of 1940! Employment in the allied health professions has almost doubled in just the past decade, and there is good reason to believe that it will increase another 50 percent in the next decade. New and proposed legislation may expand the role of allied health manpower in the health care system even further.

There are good reasons for this explosive growth. The increasing population is one. Our Nation has grown by more than 24 million people since the Sixties began, and we're growing larger all the time. By 1980 our population is expected to increase by another 24 million, with much of that increase occurring in those age groups that require the most health services—the very young and the very old. Increased consumer income, higher educational attainment, expanded insurance coverage, and continuing efforts to bring medical care to the disadvantaged are other expected developments which will add still further to the demand for health manpower.

The increasing sophistication of health technology is another factor contributing to the size of our allied health manpower pool. Who provided inhalation therapy 30 years ago? We scarcely had such a concept. Yet today inhalation therapists are essential workers, with 14,000 currently employed. If my information is correct, at last count there were more than 125 occupations and professions, many of them new, which might be considered as full-fledged members of the allied health field.

Some of these new faces in the allied health crowd are the result of shortages in the other health professions. We've been talking about physician "shortages" for more than 40 years. In 1930 a study group estimated that the Nation had 13,000 physicians fewer than the number needed to provide adequate preventive, diagnostic, and curative services. That deficit has been creeping upward ever since. It now stands at 50,000. Simultaneously, 150,000 nurses, 30,000 dentists, and 250,000 more allied health personnel are also needed. I won't debate the preciseness of these figures, but they do represent a very definite inadequacy in all these professions.

Where does the buck stop when the demand for medical services is skyrocketing in one direction, and the inadequacy of the health manpower pool is growing in the opposite direction? Within certain limits, this is the kind of thing that happens:

If there aren't enough registered nurses, the L.P.N. must help take up the slack. If the L.P.N.'s are all busy, perhaps the nursing aide can perform certain tasks.

If a pediatrician is booked solid, six days a week, somebody else is going to have to do his lab work for him—somebody else is going to have to take his X-rays. His accident patients—perhaps even quite minor ones—may wind up being referred to a hospital emergency room. There, incidentally—where fast action and efficiency are important—the division of labor is even more apparent as squads of clerks, technicians, assorted nurses and specialists function in a kind of medical repair factory. Gradually we become more efficient. At the same time, our system and work become more complex, and we still haven't eliminated the inadequacies.

It costs a great deal to keep an industry running at peak capacity. The law of supply and demand (temporarily suspended until November) exacts a toll. Moreover, such factors as increased wages for medical help and the expenses of new medical technology preclude many cut-rate bargains in the Nation's health bills.

The Nation's expenditures for health care are rising at the rate of almost 13 percent a year and are expected to continue mounting at least until 1974 when they may exceed \$100 billion.

A recent study by the Department of Health, Education, and Welfare estimates that if the Administration's health insurance plan were adopted, the Nation's health bill in 1974 would be \$107 billion—\$40 billion more than last year. But, also according to the study, even if *no* national health insurance plan were adopted, Americans would still be spending about \$105 billion for health care in 1974.

The health insurance bill is just one of several pieces of health legislation being studied by Congress now that the lawmakers have returned from vacation. Some of it will help your professions and some of it will add to your problems, but virtually all of it will have some implications for the allied health field.

Recognizing the growing importance of allied health manpower, the Administration requested—and Congress has already enacted—a record appropriation for the Division of Allied Health Manpower in the Bureau of Health Manpower Education.

The Division's appropriation for Fiscal 1972, just over \$30 million, is almost twice as high as last year's. Some of these funds will go for broadened special project grants, a new grant program authorized under the Health Training Improvement Act of 1970.

The Division recently awarded its first special project grants under this legislation, \$4.5 million for the training of physician assistants and health manpower in such fields as nuclear medicine, inhalation therapy, environmental health, physical therapy, dietetics, medical record technology, medical physics, and cardiovascular technology.

Still awaiting Congressional action is this year's health manpower legislation, now undergoing modification in conference committee. As I'm sure you know, the Health Manpower Act of 1968 expired on June 30, and the conference committee is now trying to reconcile two different versions of an extension and improvement of the old legislation.

The House version authorizes a three-year, \$2.8 billion support program. The Senate model authorized a five-year, \$5.9 billion program.

Among its provisions, the Senate bill encourages training for new kinds of health personnel, including physician assistants, dentist assistants, and other health professions assistants and nurse practitioners. The Senate bill also specifically provides funds to schools of medicine, osteopathy, and dentistry for the training of physician assistants, dentist assistants, and other health professions assistants.

The House bill, carrying a \$270 million authorization over the next three years for the Health Manpower Education Initiative Awards, would use most of this amount for establishing Area Health Education Centers, a concept advanced in the recent Report of the Carnegie Commission on Higher Education.

These centers would link education and service institutions to increase the supply of health personnel in shortage areas. The training would stress the team approach and increased utilization of, and responsibility for, non-physician personnel.

Training in the team approach and development of allied health personnel also would be encouraged in the House bill through special project grants.

In addition, the conference committee is deliberating on new authority for nurse training. Both bills under consideration would extend support for nurse training for three years.

The new legislation would, for the first time, support training for auxiliary nursing personnel. In the past such legislation was restricted to the training of registered nurses. The new legislation acknowledges that registered nurses, like physicians, can be more effective when supported by auxiliary workers.

The House bill authorized \$83 million for special projects to train new kinds of nursing personnel, such as pediatric nurse practitioners. It also would support projects to develop cooperative interdisciplinary training among schools of nursing and schools of allied health and the health professions.

Another Administration program, the National Health Service Corps, authorized last year, is preparing to send health teams to underserved inner city and rural areas beginning late this fall.

The Corps plans to put about 620 health personnel into the field by next July. About 300 of them will be nurses and allied health personnel.

One of the problems contained in the pending legislation is in the form of the built-in demands for more manpower for the allied health professions. I mentioned the need for an additional 250,000 allied health workers that exists today. But even more manpower will be required, for example, to serve the Health Maintenance Organizations, "the HMO's" our name for comprehensive prepaid group practice plans. The HMO's are a key element in the President's health strategy. They literally require increased utilization of allied health personnel.

Pending legislation would enable us to program approximately 60 new HMO's in the planning stages and put 50 more in the beginning operational phases during this fiscal year.

An HMO option is also an integral feature of the Administration's health insurance plan that is now before Congress, and HMO care for Medicare and Medicaid recipients would likewise be encouraged in the Administration's welfare reform bill.

In that same bill, however, is another provision which has a direct impact in the allied health field. The bill recommends the adoption of a system of proficiency testing for recruiting and upgrading health personnel in the Medicare and Medicaid programs. It would require the Secretary of HEW to develop and use proficiency tests to determine the work qualifications of health personnel who do not meet the formal criteria now included in Medicare regulations. The testing would be used both to recruit and to upgrade practical nurses, therapists, technologists, technicians, and other health care personnel.

The health insurance bill also addresses itself to barriers to the use of allied health personnel. For example, one section of the bill would override those State laws which inhibit the operation of prepaid group practices. Most of our States have some restrictions to HMO development, as for example with regard to licensure or sponsorship.

This same legislation also would lift legal barriers that impede the use of allied health personnel in Federal programs. A physician affiliated with an HMO could delegate any of his functions to a person who is employed either by himself or the organization. No State law or regulation could penalize any physician, employee, or organization for such action. In performing delegated functions, of course, an employee would have to comply with criteria to be set by the Secretary of Health, Education, and Welfare.

Closely related to increased delegation of functions and greater use of allied health personnel is the question of malpractice. Fear of liability has undoubtedly discouraged physicians from delegating functions. Remember that a physician-employer is liable for injury caused to his patients by the negligence of any of his employees, regardless of the employee's credentials.

This and other problems of medical malpractice will be addressed by Secretary Richardson's recently announced Commission on Medical Malpractice.

This brief legislative litany, I think highlights some important aspects of the allied health field. There is, *first* of all, the virtual certainty that our predictions of continued growth in the allied health field will be fulfilled. *Secondly*, legislation is slowly and progressively building the use of allied health personnel into a developing system of health care. We're still trying to produce more physicians, for example, but we're trying to produce a more efficient physician,

working in a setting that makes effective use of the skills and services of supportive and collaborative personnel. And *thirdly*, there is discernible in all this legislation the need for input from you—the allied health professionals themselves—a need for the advice and counsel of those who can speak authoritatively for the allied health field, of those who are responsible for the orderly development of this field.

Secretary Richardson's recent report to Congress on Licensure and Related Health Personnel Credentialing represents one effort to find such counsel and to present it to the Legislature for use in future health programs.

I have special responsibilities as a result of the report, including a study of the feasibility of establishing a national system of certification for certain categories of health personnel. This study, obviously must be undertaken in close working consultation with the professional organizations in the allied health field. My exposure to the intricacies of this particular manpower problem is relatively recent, and if that poses some difficulties—both for me and for you—it at least enables me to view this problem with some degree of objectivity.

Quite frankly I will be seeking from *you* the facts and opinions, which hopefully, can provide some of the framework which will ensure the orderly development of this field. Any such effort is doomed without your cooperation.

If I come into this situation with few preconceptions, the ones I do have are quite strong. At several points in the Secretary's report one admonition is repeated. Such devices as licensure, certification, and accreditation have as their original purpose the protection of, and service to, the public. Their use *must contribute* to manpower solutions, must provide for a flow of qualified personnel into the health field. They should *not* constitute needless hurdles to be overcome in the delivery of services. I firmly subscribe to this concept. There are barriers enough to the health professions—time, money, manpower, energy. We must not create any artificial tariffs that might exclude able workers from a field which is already having difficulties enough providing services to all who need them.

My other preconception has to do with the *proliferation* of health occupations. The need in the allied health field is great enough to encompass many occupations and professions, and I'm certain that others will develop in the years to come. But this new development, and indeed the plethora of professions already in existence, must fit together in some orderly manner. Our manpower pool is simply not great enough to permit anything but the most efficient organization of services.

Inherent in the proliferation which the health field has been experiencing is the danger that too many of the allied health professions may elect to go their separate ways, speaking and even acting at cross-purposes with the rest of the allied health world—without consideration for the overall picture. If this sounds a bit strong, let me ask which of you, right now, can say that his profession is evolving in an orderly fashion and takes into consideration the evolutions occurring in the rest of the allied health field? Who is looking at his profession from a perspective that takes into account the development of the entire allied health field? Who can speak for all the allied health professions? Who can say what it is that the allied health professions want to do, which are the directions in which they choose to move, what it is they wish to recommend to Congress to help the professions improve the quantity and quality of service to the American public?

And yet, if you are to be effective, you are going to have to learn to *speak* with a more unified voice. Your professions, to be sure, do have legitimate differences of opinion, different interests, and different approaches to your problems.

But you will have to speak to a number of issues such as the wide range of health proposals now before Congress. And if you expect to be heeded, you must speak in a manner that convinces the lawmaker and the program-maker that you are speaking in the public interest and not merely to protect established ways of doing things; or to protect the ways that are best for your particular interests. If you speak with a multiplicity of voices and concerns, little will be heard, and even less will be heeded. At best, the result will be confusion; at worst, it will be inefficiency.

This brings us back again to the purpose of your meeting here. You have an opportunity to frame and strengthen the relationships among your various units by discussing common problems in a specific area of concern. There is an opportunity here to channel the inevitable growth of the allied health professions in such a manner as to provide a matching growth in service to the public.

I interpret this conference as evidence of your willingness to come together to discuss common problems. The remarkable growth of the Association of Schools of Allied Health Professions itself, founded only four years ago, is another indication of a recognized need to cooperate.

I sincerely hope that these efforts to bring order to the allied health field will continue and that with your cooperation we can jointly develop and carry out programs that will assure an adequate supply of the full range of allied health professions, efficiently and economically providing services to the public.

CHAPTER III—RESOURCE PAPERS

The Planning Committee invited national professional associations to provide Resource Papers for the conference. In those cases where the profession had a certifying agency distinct from the national professional association, the certifying agency was requested to submit information about its activities for inclusion in the professional association's presentation. The Resource Papers were to discuss: (1) credential process(es) utilized, (2) reason for selection of the process, (3) purposes served by the process, (4) problems encountered in implementing the process, and (5) planned improvements not implemented and the reason why. The papers reproduced here are those submitted by each professional association.

- American Association for Inhalation Therapy
- American Association of Medical Assistants
- American Corrective Therapy Association
- American Dental Assistants Association
- American Dental Hygienists Association
- American Dietetic Association
- American Medical Record Association
- American Occupational Therapy Association
- American Orthotics and Prosthetics Association
- American Physical Therapy Association
- American Society of Medical Technologists
- American Society of Radiologic Technologists
- American Speech and Hearing Association
- National Environmental Health Association

AMERICAN ASSOCIATION FOR INHALATION THERAPY

Type of Credential Process

Inhalation Therapy presently has two levels of credential processing. Both are national in scope.

- The American Registry of Inhalation Therapists has been active since 1961. It is an incorporated legal entity unto itself, sponsored by and composed of members from the American Association for Inhalation Therapy, the American College of Chest Physicians, and the American Society of Anesthesiologists. It offers an annual written examination and two oral examinations in any given year. Numerically it is physician dominated.
- The Technician Certification Board, which operates as a committee of the American Association for Inhalation Therapy has been fully operational for less than one year. It is currently composed of six Inhalation Therapists and four physicians. Each physician represents a different physician organization which would normally be expected to have an interest in Inhalation Therapy. (The Board is intended to be represented by six Inhalation Therapists and six physicians. However, two physician organizations have yet to name a representative.)

Reasons for Selection

- The American Registry of Inhalation Therapists was organized to meet a need to measure the technical knowledge via a written and oral examination for practitioners in the field. Licensure was almost universally felt to be such a low level measure of technical and clinical ability, fraught with 50 potential variations, and precluding almost all possibility of education and structure improvement that it was never seriously considered initially.
- The Technician Certification Board filled a need to give credentials to practitioners with a lesser depth of knowledge than the ARIT requires. It was designed to establish a minimum level of knowledge for Technicians working in the field. Persons qualified for this examination are generally not as highly qualified as examinees for the ARIT examination because they usually do not possess an extensive, formal knowledge, particularly in relation to science-related subjects.

Criteria

- The ARIT originally admitted candidates to their examination, proving two years of continued work in the field under medical supervision, membership in the AAIT, plus a high school diploma or its equivalency. (This was the era of the "grandfather clause" provision.) Standards were subsequently raised and an associate degree in Inhalation Therapy is now the primary means of obtaining application acceptance.
- The CTB program is designed to officially certify those Inhalation Therapy Technicians who: a. have some degree of training, b. are technically competent in the field, and c. demonstrate their competency by passing a written examination for certification. An applicant is eligible to sit for the examination provided he is a member of the AAIT, is employed in Inhalation Therapy under medical supervision, has a high school diploma

or equivalency, and has had two years experience in the field at the time the application is filed.

Purposes

- Principal achievement of the ARIT is the maintenance of a registration list of persons felt to be qualified to provide quality patient care requiring Inhalation or Respiratory Therapy under medical supervision. Many of these registered therapists are increasingly involved with a variety of teaching programs and administrative and supervisory positions.
- The single principal achievement of the TCB has been to give some credential to persons who would otherwise not be able to have any. The program is very young, and therefore, trends are difficult to identify. At this very early stage, however, it appears that the ARIT is providing "chiefs" while the TCB is providing technically competent "Indians".

Problems

- The ARIT had the problem of the original total absence of almost all criteria for school essentials and education other than on-the-job programs which prevented any advance selection other than experience. Later, with the "Essentials" provided by the American Medical Association regarding accreditation of schools, the problem greatly diminished. Over the past few years the associate degree programs, some effectively affiliating with an in-existent hospital-based clinical program, but others arising de novo, have added a broadened educational basis to the field. Four baccalaureate programs are now in existence.
- The TCB problems encountered were manifold. Individual physician resistance to the original idea was manifested to such a degree that at the organizational meeting of TCB two physician representatives from the ARIT, walked out in the middle of the meeting. Establishment of an educational level was another problem encountered. Problems still facing the TCB include a moderate amount of financial difficulty, an inadequate "pool" of questions for future examinations, and group physician support. (Two physician groups have yet to appoint a representative to the TCB as was requested of them.)

Planned Improvements

- The ARIT is planning moves for vertical mobility and also lateral mobility. The concept of Certified Inhalation Therapy Technicians being considered qualified to take the Registry Examination is being investigated, but the TCB's direct connection with the AAIT has delayed inner-connections.
- The TCB is still very young and therefore plans are still developing. Among other things, TCB is planning a possible incorporation thereby becoming legally separated from the AAIT. The TCB is also concerned with upward mobility from the Certified Technician to the Registered Therapist. Essentials have been written for a one-year training program, but a mechanism for the accreditation of such programs have not yet been developed. The "grandfather clause" will expire in 1975, at which time only candidates will be accepted who have graduated from an accredited one-year program.

AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

Objectives of Certification Process

- To establish professional standards and goals for medical assistants.
- To help physicians identify competent medical assistants, administrative and clinical.
- To equip medical assistants for improved performance and greater responsibilities, thereby allowing the physician more time for patient care.
- To prepare and distribute complete information concerning the certification process.
- To certify by official means those individuals who successfully complete the examination.

History of the Program

The American Association of Medical Assistants approved the formation of a Certification Committee in 1959. In 1961 the Certifying Board was established, and the pilot test was given at the Detroit convention in 1962.

In 1963, the first examinations were given in three locations: Florida, Kansas, and California. Of the 108 medical assistants who took the examination, 24 passed—eight in administrative, fifteen in clinical, and one in both sections.

The Certified Medical Assistant receives a certificate stating her achievement and wears a special CMA pin denoting her status as a top-level employee.

As of June 1971, there were 603 CMAs, and the total is expected to increase rapidly in the next few years.

The two-day written examination has been given annually on the last weekend in June at more than 50 test centers. Effective in 1972, the test will be limited to one day—the fourth Friday in June.

Because of the many duties the medical assistant is expected to perform, two categories were established: administrative* and clinical. However, the medical assistant may take both sections and obtain a dual certificate. As of 1971, medical assisting instructors and students may take the examination under special eligibility requirements.

In 1969 a "Mini-Test" (simulated test) was developed to answer some of the questions about the examination and to encourage more medical assistants to take it. The Mini-Test is about one-fifth the length of the real examination and consists of questions used in previous examinations or their equivalent. By using a number code system, only the candidate knows her score on the list posted. This test has been given at two annual conventions and has proved to be effective in reducing the fear of failure.

In order to widen experience of taking an examination, the Mini-Test was made available to state conventions. The first state test was administered in North Carolina in the fall of 1970. During the spring of 1971, fourteen other states offered the Mini-Test at their annual meetings.

To help applicants prepare for the examination, AAMA provides a study outline and reference list.

Beginning in 1972, the AAMA Certification Examination will consist of three major divisions.

*The term "administrative" is used here synonymously with "secretarial, clerical and/or office-managerial," depending upon the division of duty in a particular office and the amount of responsibility carried.

Reasons for Selection

At the time the AAMA Certification Program was established, there were very few courses in medical assisting and no recognized standards for a medical assisting curriculum.

The process was selected by a group of medical assistants, physicians and educators who studied the field and selected those areas in which medical assistants should demonstrate competence. The written, multiple-choice format was selected for objectivity, efficiency, and economy.

Criteria

The original requirement for AAMA Certification was that of experience only, i.e., three years of employment in a physician's office. However, the examination is not a measure of personal job performance, and home study is necessary for those with little or no formal education beyond high school.

Now that AAMA has established curriculum standards for training medical assistants, students in AMA—AAMA approved programs will be able to take the examination.

The content of the AAMA Certification Examinations is prepared by certified medical assistant members of the Certifying Board, with assistance from educational consultants and physicians. Examination items are based on the knowledge which these individuals believe a medical assistant should have and be able to apply in a physician's office.

All materials are field tested among certified medical assistants before being used in the examination. After materials are field tested, the Certifying Board selects those items that "performed well" in the field test; that is, those items which meet certain criteria set by the Certifying Board.

These criteria would include a high level of agreement among the field testees as to the best answer to the item and agreement among the field testees that the item tested is an important fact or concept. Through the field test procedure, the AAMA ensures that the certification examination contains reliable, valid questions that relate to the degree of competency sought in the field.

Professional Consultation

For a number of years AAMA benefited from the advice and counsel of a university educator well versed in certification procedures. However, as the program grew, his limited time did not permit desired expansion of the program.

Therefore, to improve the quality of Certification examination, validate the results, and provide helpful counsel to candidates, Natresources, Inc., an educational consulting firm in Chicago, was engaged in 1970 as part of a board program of educational evaluation. This firm is working on the programs of Certification, Education, and Curriculum Review in an effort to increase the efficiency and effectiveness of medical assistants.

With the exception of the typing portion, the entire examination is computer-scored and analyzed. Feedback to participants includes:

- Notice of success or failure per section.
- Score per section, plus the average score of all candidates per section.
- Subtest scores within sections, i.e., each section is divided into five to eight content areas which are scored individually.
- An explanation of how to use the computer feedback data.

AAMA and its educational consulting firm believe that the certification examination itself and the feedback to candidates are important educational tools. The feedback enables candidates to identify their strengths and weaknesses, thereby showing them where to direct their study.

Type of Credential Process

AAMA administers only a certification program and has no registry or licensure.

Because the duties of a medical assistant are so varied it would be virtually impossible to adopt or administer a licensure program. Although a medical assistant may concentrate on either the administrative or clinical area, she is sometimes called upon to substitute in the other area when one of her colleagues is absent from the office.

The possibility of a registry for graduates of approved programs is a future possibility.

Eligibility for Certification

Membership in AAMA is *NOT A REQUIREMENT* for Certification testing.

Applicants for certification must have a high school diploma (or equivalent), plus one of the following combination of experience and/or education:

FOR THOSE WITHOUT FORMAL EDUCATION

Three years of experience to sit for either the clinical or administrative certificates.

Four years of experience to sit for the administrative-clinical certificate.

FOR THOSE WITH SOME FORMAL EDUCATION

An associate degree in medical assisting or equivalent, plus 1 year of experience to sit for either the clinical or administrative certificate.

An associate degree in medical assisting plus 2 years of experience to sit for the administrative-clinical certificate.

FOR MEDICAL ASSISTING STUDENTS

Students wishing to take the examination must be willing to sit for the Dual Examination (both Administrative and Clinical).

- **For Those Enrolled in a Two-Year Program**

Students in the second year of an associate degree or two-year certificate program approved by AMA-AAMA may apply by February 1, prior to his/her graduation and if accepted, may sit for the examination. Application must be signed by the medical assisting instructor. Results will not be released, nor will certification be granted to successful candidates until proof of graduation has been received by the chairman of the Certifying Board.

- **For Those Enrolled in a One-Year Program**

A medical assisting student enrolled in a one-year AMA-AAMA approved program may apply for the Dual Certification Examination by February 1, prior to the date of his/her completion of the program, and if accepted, may sit for the examination. Application must be signed by the medical assisting instructor. Results will not be released until proof of successful completion of academic training is received by the chairman of the Certifying Board. For those who pass the examination, certification will be granted after proof of completion of one year of experience in the medical field.

FOR MEDICAL ASSISTING INSTRUCTORS

Medical assisting instructors are eligible to apply if they are teaching in (1) a school accredited by one of the regional accrediting agencies which is a member of the Federation of Regional Accrediting Commissions of Higher Education or (2) a vocational-technical, proprietary or military-based institution offering an AMA-AAMA approved medical assisting program. Application must be signed by the Dean of Education.

Problems

In the early years of the Association, a certification program was established before there were existing standards for a medical assisting curriculum. Therefore, it is only recently that there has been any coordination between self-study and formal education.

Also, the leaders who established the program made no provisions to grandfather (or more properly, "grandmother") the experienced medical assistants in the organization. Had this been done, some internal resentments might have been avoided.

Because the early examinations did not have the benefit of adequate professional consultation, the failure rate was extremely high. Thereafter, many experienced and competent medical assistants, once they learned how difficult it was to pass the test, refused to take it. Consequently, the number of certified individuals increased rather slowly.

In 1968 a realistic appraisal of the program began to improve the situation, and efforts were made to validate the test questions more thoroughly. The number of passing candidates has gradually risen, and the 1971 percentage was the highest in history.

Nevertheless, efforts will continue toward achieving a greater number of applicants and a larger percentage certified each year.

It has been observed that candidates do not seem to be prepared along the lines supported by the AAMA Certifying Board. Their educational backgrounds and study patterns are extremely varied. This can be attributed to the fact that until 1969 there were no accredited educational programs. This problem will gradually be alleviated, especially since one-year programs are now subject to approval by the AMA-AAMA.

Another factor to be taken into account is the dual role of the Certification Examination—that of promoting education and recognizing competency. Although there is—and should be—some natural overlap between the two roles, the primary function of the Certification Examination is to recognize competency.

Some worrisome developments occurred during the summer of 1971 which point up the proliferation of accrediting and certifying agencies in the allied health field.

The American Medical Technologists are establishing a registry for medical assistants and will seek to certify them through a written examination. Moreover, the Accrediting Bureau of Medical Laboratory Schools is already accrediting medical assisting programs in junior colleges as well as proprietary schools.

As of this date, the U.S. Office of Education has not recognized any group as the accrediting agency for proprietary school programs in medical assisting. AAMA is preparing documentation to substantiate its qualifications in this regard.

Another recent problem is the newly emerging career known as "physicians assistant." Although there are marked differences in the two programs, it is unfortunate that terminology should create such a state of confusion.

Planned Improvements

Most of the planned improvements have not been implemented because of lack of funds. However, they have not been discarded but rather held in abeyance until monies are available.

Recommendations for improvements are now being considered for such time as funding can be provided:

- A proposal for a Guided Home Study Program for medical assistant
- An in-depth analysis of the duties of a medical assistant. The University of California, Los Angeles, has made a survey of medical assistants regarding job responsibilities, with results scheduled for the fall of 1971. After these are analyzed, further plans can be based on sound findings.
- Enlargement of the AAMA professional staff to ease the load still borne by volunteer members of the Association.

Outlook for the Future

One definite possibility for the future is that of specialty certification for medical assistants. Early in 1971 the AAMA Certifying Board affirmed its interest in working with specialty societies toward this goal by the following resolution:

WHEREAS there is indication that specialty certification for medical assistants is the trend of the future, and

WHEREAS AAMA is already working with the specialty societies on curriculum development, and

WHEREAS it is desirable for AAMA to be consistently identified with the certification of medical assistants, and

WHEREAS the AAMA Certifying Board and its test consulting agency possess a valuable reservoir of knowledge in the field, therefore be it

RESOLVED, that the Certifying Board express to specialty groups who may desire certification of medical assistants in their respective specialties a pledge of cooperation and assistance in working out the mechanics and implementation of such a program.

The next few years should bring marked progress for the following reasons:

- The American Medical Association has shown a renewed interest in the progress of AAMA and has demonstrated this by a grant of funds in 1971 and an increased budget allocation for 1972.
- There are prospects for additional grants from the pharmaceutical industry and other private sources.
- More medical assistants will be involved in the preparation of certification examination materials.
- There should be improved communication among the applicants for certification, medical assistants in the field, and medical assisting instructors in approved programs.
- Many more schools will be correlating their curricula with the certification study outline.
- Additional numbers of students will be sitting for the examination.
- The test will be geared more to practical application than the mastery of textbook material.
- More and more physicians will recognize the value of employing Certified Medical Assistants in their offices.

AMERICAN CORRECTIVE THERAPY ASSOCIATION

In 1953 the Association for Physical and Mental Rehabilitation (the precursor of the American Corrective Therapy Association in 1967) initiated a process of certification of its members for the practice of corrective therapy. It was felt then, and the philosophy continues to the present time, that voluntary examination and certificate verification of one's professional qualifications by his peers through the Association is the most feasible means of establishing and maintaining quality standards of personnel preparation. It is obvious that every profession must exercise some control over the standard of preparation of those who hold themselves to practice therein. Thus, this Association determined the range of academic and clinical training requisites for formal examination leading to a Certificate in Corrective Therapy.

Criteria

The criteria for obtaining a Certificate in Corrective Therapy is as follows:

- Hold at least a bachelor's degree in physical education from an accredited institution, which includes or was obtained in addition to, the following minimum course work: 12 semester units in Applied Sciences, 6 semester units in Psychology, 16 semester units in Health and Physical Education, and 8 semester units in Corrective Therapy and Adapted Physical Education.
- Four hundred clock hours of clinical training in an approved corrective therapy clinical training affiliation (may include up to 160 hours on-the-job experience).
- Hold Active Member status in the American Corrective Therapy Association.
- Successfully complete both written and oral phases of the Examination for Certificate in Corrective Therapy.

Purposes

This process serves to establish and maintain a standard of didactic and clinical preparation deemed by the practitioners of the profession to be the minimum required for knowledgeable practice. The examination is the only tool at hand for adequately determining the effects these training phases have had upon the individual, and to assess his immediate competence in the skills of the profession. The purpose of the membership requirement is obvious; the Association can neither vouch for nor exercise any control over non-members. The Certified Corrective Therapist holds forth documentation of his training and competence, and is in a more advantageous position professionally.

Problems

The primary problem this Association has had in the implementation of its certification process involves the creation of new, updating old, and packaging existing courses into programs at the colleges and universities that meet stated academic needs. Secondly, the establishment of examination stations, times and personnel that creates the most objectivity in testing and the least travel and expense to all concerned must undergo continual scrutiny. Thirdly, attempts at standardization of clinical training experiences in a broad variety of environments across the nation has presented problems. And fourthly, realistic and just equation of knowledge and experience gained in other than recognized collegiate environments remains arbitrarily confined.

Planned Improvements

The academic standards which served well to establish the preparatory base of the profession were of necessity very rigid, but with an ever expanding sphere of practice and demands for greater degrees of flexibility among health professionals. These requirements must be broadened to meet these expanded needs. The official examination itself is presently undergoing revision, and will allow for a wider range of experience and practice applicability, or the opportunity for concentration within an area of rehabilitation. Further, the certification process may no longer be considered a lifetime endorsement of competence, but should carry with it requirements for continuing education and periodic re-examination.

For detailed explanation of the certification process of the American Corrective Therapy Association, you are referred to Vol. 25, No. 3, May-June, 1971 issue of *The American Corrective Therapy Journal*, pp. 91-93, "Corrective Therapy Certification Policies and Procedures" by Warren C. Smith.

AMERICAN DENTAL ASSISTANTS ASSOCIATION

Type of Credential Process

The Certifying Board of the American Dental Assistants Association is a national independent certifying organization and is not sponsored by any governmental agency. Certification is the only process utilized by the ADAA.

Reasons for Selection

The Certifying Board was established in 1948 and at that time, the founders could not foresee in the near future when there would be licensure for dental assistants. Therefore, certification was chosen as the method of recognizing those dental assistants who had obtained a certain amount of training.

Criteria

The first requirement is completion of a minimum of one year of training in a post high school course in a school accredited by the Council on Dental Education of the American Dental Association. Secondly, the applicant must successfully complete a comprehensive written examination and a practical exam. It is important to note that certificates expire and must be renewed annually. This is done on the basis of participation in continuing education courses.

Purposes

Certification, as we see it, identifies those dental assistants who have acquired basic knowledge in dental assisting as established by the ADA Council on Dental Education. In addition, the certification examination is being used in some states as the base line for choosing certain assistants to perform expanded duties. Certification is the only criteria currently available which enables us to identify those dental assistants that are knowledgeable in their field. Current certification also serves to identify those dental assistants who are involved in continuing education to improve the quality of services rendered.

Problems

The problems which have been encountered are not unique and are ones that would arise with any new testing agency. Some of the more significant problems were:

- Insuring that the exam was related to what the dental assistant actually does in the office
- Developing an examination that has sufficient coverage and depth
- Gaining recognition by the dental profession
- Impressing upon the dental assistant the worth of the program, thereby getting her participation.

Planned Improvements

No major improvements planned. Examination is continually changing, in that it is reviewed and improved on an annual basis.

AMERICAN DENTAL HYGIENISTS ASSOCIATION

Type of Credential Process

Dental hygienists are the only auxiliaries in the field of dentistry who are required to have a license to practice. This requirement is uniform in all 50 states. Administratively, dental hygiene licenses are granted through state boards of dentistry. Unlike most other licensed personnel at the professional or paraprofessional level, dental hygienists are not directly involved in their own examination and licensure, though increasing numbers of dental boards are utilizing dental hygienists in some consultative capacity.

Reasons for Selection

Dental hygienists initially became licensed because the service they provide was originally part of the clinical practice of dentistry. The oral prophylaxis, which remains as their main clinical function, is still considered a dental procedure which can be performed only by a licensed dentist or dental hygienist. Whether or not licensure will always prove to be the most effective form of regulation for dental hygienists is perhaps a moot point; but, as a dental procedure, complete oral prophylaxis should by no means be considered a minor procedure which requires little skill.

The oral prophylaxis is a clinical procedure in which instruments such as scalers, curettes, and a dental handpiece are used. The object of the procedure is the removal of calculus, dental plaque, and other debris from all tooth surfaces including the interproximal surfaces and surfaces of the tooth beneath the gingiva, which are not attached to the gingiva. By some definitions, the prophylaxis may also include a procedure called root planing, or the smoothing of root surfaces using a curette or a file, and soft tissue curettage which is the removal, with a dental curette, of necrotic or edematous gingival tissue which lines the tooth socket. The object of both of these procedures is to reverse the pathology which advances the development of periodontal pockets, abscesses, bone resorption, and ultimate tooth loss. In some states, the dental laws treat root planing and soft tissue curettage as separate procedures which can be performed only by a licensed dentist.

The performance of a complete oral prophylaxis, particularly in a diseased mouth, is both difficult and time consuming. The operator must have dexterity in the use of instruments, indepth knowledge of oral anatomy, and knowledge of oral pathology. When instruments are used beneath the exposed or visible portions of the tooth structure, visual monitoring is not possible; and the dental hygienists must rely upon tactual skills and knowledge of the general "terrain." Certain physical conditions, systemic or local, constitute clear contraindications to the procedure or may require the use of various forms of premedication. Hence the need for a working knowledge of pathology.

Criteria and Purposes

The main criteria used in determining eligibility for licensure in dental hygiene are, for all intents and purposes, uniform among states. Only one state does not require graduation from an accredited training institution, and all states require satisfactory performance on a paper and pencil examination. In this regard, the National Board of Dental Hygiene Examinations are accepted in all but four states. Clinical examinations are required in all states but, with a few exceptions, do not serve as discriminating criteria. Great reliance is obviously

placed upon the clinical training and evaluation which takes place during formal education. The following data lend support to this statement:

• Total number of licensing jurisdictions requiring formal educational credentials	50
• Number of jurisdictions with no failures in clinical examination	35
• Number of jurisdictions with less than 5% failure	6
• Number of jurisdictions with more than 5% failure	9
• Total number of candidates, all jurisdictions	2802
• Total number of failures, all jurisdictions	90

The clear purpose for the criteria which exist is to safeguard the public. The necessity for dental hygienists to be fully prepared for their role on the dental health team becomes more apparent when it is realized that, in practice, the dental hygienist is the first person to see a patient and completes her service to the patient without immediate supervision or consultation. The dentist frequently does not see the patient until after the dental hygienist's work is complete. In the treatment of more difficult patients, the dentist's opinion or direction is required. The dental hygienist's ability to distinguish between the routine and non-routine is critical, and this judgment must be made upon the recognition of signs which are often subtle to the untrained eye.

Problems

While it seems clear that effective regulation of dental hygiene practice is essential, the mechanism has certain negative characteristics. While the major criteria used in determining the eligibility of a dental hygienist for licensure are uniform in most states, the technical authorities given dental hygienists in different states vary considerably. Many laws, if rigidly interpreted or enforced, would prevent dental hygienists from practicing dental hygiene or require such extensive supervision that the hygienists would be of no value in the delivery of care.

A critical problem exists in the fact that, on a natural basis, very little progress has been made in the direction of establishing meaningful forms of reciprocity or recognition of existing credentials. While the flexibility observed in the issuance of automobile operators' licenses may never be observed in the regulation of health practitioners, and perhaps flexibility in that degree would not be desirable, the alternative should not be to keep qualified and needed personnel from the practice of their art for long periods of time. Currently, 19 states have only one examination period each year; and the majority of the states that remain have two. On the positive side, there are 11 states that now have provisions for granting temporary licenses; and this number is increasing.

THE AMERICAN DIETETIC ASSOCIATION

In 1969 The American Dietetic Association established a program of registration for dietitians. At the time the process was initiated, there was a 3-month grandfather clause. With its termination, qualification privileges were closed. Currently, the requirements for registration are (1) membership in the Association, (2) an initial successful completion of a written examination, (3) completion of 75 clock hours of continuing education every 5 years, and (4) payment of a fee. Re-instatement of dropped registration requires successful completion of a written examination.

The responsibility for the operation of the registration program, including the rules and regulations governing the administration of the program, is housed in the elected Standing Committee on Professional Registration, while changes in standards and qualification must be submitted by the Committee to the Association House of Delegates and the Executive Board. Within the Standing Committee on Professional Registration are five panels. They are charged as follows: Panel 1—to approve continuing education hours; Panel 2—to review and evaluate the registration system; Panel 3—to develop and review the testing program; Panel 4—to review denial and revocation of registration; and Panel 5—for communications and public relations.

In its commitment to the right of every individual to receive quality health care by competent practitioners, the Association is dedicated to education of excellence not only in the primary development, but also for the continuing competency of all dietetic practitioners. Thus a purpose of registration is to assure continuing competency of dietitians to practice in health promotion.

Legislative efforts leading to licensure are expensive and the results not always predictable. It was felt the Association, with its high and clear educational requirements, could assist the profession of dietetics best in achieving the goal of competent practitioners through a program of voluntary registration. The latter as a national program would avoid the reciprocity problems of licensure, but would lead to licensure if it was felt the latter was needed.

The program of registration was voted into existence by a vast majority of Association members. During the grandfather clause period 19,000 of the then 21,000 members of the Association applied for registration. Currently 92% of the members maintain registration.

One of the problems in the development of the program has been the construction of written examinations that go beyond the testing of book knowledge to measure the proficiency required for the delivery of service. Working jointly with a professional examination service, this situation is being corrected.

Another problem has been communicating adequately with dietitians regarding the perimeters of activities acceptable as continuing education for registration clock hours.

Currently, to help reduce the burdensome policing of clock hours and to assist individuals in identification and recording of their hours of continuing education, a program of self-certification is being planned. In this program individuals will select and report annually those continuing education opportunities experienced which are in accord with their own individual professional goals. Current guidelines for selection of continuing education hours will be refined to serve individuals in their self-certification efforts.

The dietitian is the leader of the dietetic team. Two other practitioners constitute the supportive personnel. They are the dietetic technician and the dietetic assistant.

Currently, consideration is being given to the establishment of a program of certification for the technician. At the moment certification is not anticipated for the dietetic assistant (more commonly known as the food service supervisor in the health field). Since, however, the Association is involved in a process of approval for the programs educating these individuals, the question of their certification may arise in the future.

Whatever processes will contribute to the competency of all dietetic practitioners and other health personnel, and to the provision of quality care to all people, will be of concern to The American Dietetic Association.

AMERICAN MEDICAL RECORD ASSOCIATION

The American Medical Record Association advocates national certification by the peer group of professional practitioners in the medical record field rather than state licensure of individual practitioners. Its national qualifying examination programs of *Registration* of Medical Record Administrators * and *Accreditation* of Medical Record Technicians are based upon that philosophy.

A permanent national registry of Registered Record Administrators (RRA) [formerly Registered Record Librarians (RRL)] has been maintained by the AMRA since 1932, and of Accredited Record Technicians (ART) since 1955.

Type of Credential Process

National qualifying examinations are given annually for the Registration of Medical Record Administrators and the Accreditation of Medical Record Technicians. The AMRA develops the content of the examinations with the assistance of The Psychological Corporation, New York, the official testing agency, through committees composed of educators and practitioners in the medical record field.

Testing sites are arranged throughout the United States and in other countries if necessary. The testing agency tabulates and reports examination results, carries out item analyses and provides consultation for continuing evaluation and improvement of the national qualifying examinations.

Qualifications

REGISTRATION: Graduates of AMA-AMRA approved educational programs for medical record Administrators are eligible to take the national qualifying examination for designation *RRA—Registered Record Administrator*. (These programs are at the baccalaureate and post-baccalaureate levels.)

ACCREDITATION: Graduates of AMA-AMRA approved educational programs for medical record technicians, and of the approved AMRA Correspondence Education Program are eligible to take the national accreditation examination for designation *ART—Accredited Record Technicians*. (These are one and two year programs at the post-high school level.)

Reasons for Selection

National certification provides national standards of professional competence and a method for evaluation and recognition by the peer group. Certification provides maximum opportunity for employment of professional practitioners anywhere in the United States, without the limiting factors of state licensure or state certification.

Criteria

The National Qualifying Examination program of the AMRA tests the subject areas specifically required for the educational preparation of medical record administrators and technicians.

* The title of the practitioner in the medical record field was changed from Medical Record Librarian to Administrator at the 1971 Annual Convention of the AMRA, House of Delegates, October 25, 1971, Chicago, Illinois.

Purposes

The program is designed to provide national standards of professional competency for Medical Record Technicians and Medical Record Administrators for the protection of the general public served—patients, physicians, allied health professionals, and employers.

Problems

- Need to consider tie-in continuing education requirement to continued certification of Registered Record Administrators and Accredited Record Technicians.
- Lack of funds for research.

Planned Improvements

Expansion of AMRA national committees responsible for examinations to provide broad input from practicing professionals and educators.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Type of Credential Process

- *Basic Professional Qualification*

Since 1935 The American Occupational Therapy Association has had a system of registration based upon established educational standards and an examination. These provide the basis for recognition of an individual to practice throughout the United States. Accreditation of educational programs is accomplished through the AMA Council on Medical Education in collaboration with AOTA. A license is required to practice in Puerto Rico, but not in any of the states or the District of Columbia.

- *Basic Technical Qualification*

In 1959 a system for the certification of occupational therapy assistants was established. It includes standards for education with the AOTA Accreditation Committee responsible for the approval of programs. Graduates of approved programs, upon recommendation of the program director, are eligible for certification as occupational therapy assistants. A temporary grandfather's clause, based upon specific work experience and reference requirements, terminated in 1963. In 1970 criteria were adopted for the certification of military-trained occupational therapy technicians on the basis of formal training and work experience.

Reasons for Selection

- The Association considers as a professional mandate the responsibility to define the activities of its members.
- These methods provide universal recognition to practice within all the states, thereby permitting freer movement of manpower.
- In summary, the present national registration and certification procedures of The American Occupational Therapy Association represent entry qualifications for rendering occupational therapy services regarded as valid by health and medical professions. These procedures are professionally determined, universally administered throughout the United States and reflect a consistency of interpretation and application in keeping with the best interest of the consumers of occupational therapy services.

Criteria

- *Occupational Therapist, Registered (OTR)*

- Graduation from an AMA-AOTA approved program in occupational therapy, plus a minimum of six months supervised clinical practice.
- Successful completion of a written examination administered by the AOTA. No practical examination is required.

- *Certified Occupational Therapy Assistant (COTA)*

Graduates of approved programs, upon recommendation of the program director, are eligible for certification as occupational therapy assistants. The addition of a qualifying examination is under consideration.

Purposes

The Association has identified, defined and elaborated standards for educational preparation and subsequently levels of performance. The profession has assumed the responsibility for the process of evaluating an individual's ability to provide and offer occupational therapy services, and is constantly surveying and

revising these services to meet and accommodate the consumer's needs. The total registration process is considered the preferred means to: (1) present a relatively standard orientation to individuals entering the profession, (2) develop and influence student attitudes regarding on-going professional competency, and (3) provide the consumer and the employer with personnel who have received similar specialized educational experiences.

Problems

- Keeping the basic preparation to practice in pace with developments of health care concepts.
- Designing examination items in keeping with current professional practice.
- Planning and implementing the multiple steps required for the total process, and accommodating the increased number of new programs.

Planned Improvements

- Study of the relevance of the AOTA registration examination.
- Development of proficiency and equivalency examinations.
- Development of qualifying examination as the final step of the process of certification as an occupational therapy assistant.
- Development and implementation of standards for continuing education.
- Further refinement of the definition of functions of all levels of practice.

The above projects are under consideration, with implementation contingent upon the recommendations from the studies and the availability of funds.

AMERICAN ORTHOTICS AND PROSTHETICS ASSOCIATION

The orthotic-prosthetic practice encompasses the providing of care to patients with disabling conditions of the limbs and spine and/or partial or total absence of a limb by fitting devices known respectively as orthoses and prostheses. The practitioner representatives are essential members of the rehabilitation effort.

The "organized" profession is represented by The American Orthotics and Prosthetics Association, which is a trade organization in the traditional sense, and The American Board for Certification in Orthotics and Prosthetics, Inc., which is the certifying and accrediting body. The former was organized in 1917 and thereafter in 1948 co-sponsored the founding of the latter in cooperation with The American Academy of Orthopaedic Surgeons which continues to have three representatives on The Board for Certification's directorate. A third organization, The American Academy of Orthotists and Prosthetists, has just been established. Each of the entities has clear-cut jurisdictional and service areas.

Type of Credential Process

- **PRACTITIONER CERTIFICATION**

The American Board for Certification has certified practitioners and facilities from the beginning. (The "facility"—or laboratory—is the organizational entity wherein or whereby orthotic and/or prosthetic care is provided to the patient in accordance with medical prescription. It may be a private, institutional or government organization.)

Practitioner certification is based upon the development of qualification capability for acceptance as a Candidate for Annual Examination administered in conjunction with a medical school orthotic-prosthetic teaching facility. The program is voluntary as far as individual participation is concerned. The purpose of the examination is to test the practitioner's over-all competency in the particular discipline regardless of the specialized nature of his practice as imposed by local circumstances.

The practice of orthotics and prosthetics was originally considered to be a "craft", principally because the fundamental function was the working of various materials to produce an orthosis or prosthesis which was then fitted to the patient by the physician. With the evolution of recognition of the allied health disciplines as being in the "professional" area, total orthotic-prosthetic care is provided by the practitioner, including advising the physician on the prescription, measuring the patient, designing and fabricating the device, and fitting and adjusting it to the patient, with basic instruction in its care and utilization.

With this development, the Association and The Board recognized that three occupational levels are required for the advancement of the profession. Therefore, current occupational descriptions and titles for the technician, assistant and practitioner levels were developed in 1970, and innovative voluntary certification programs for the former two were designed.

- **FACILITY ACCREDITATION**

The program for accrediting the facility was originated in 1948 simultaneously with the beginning of the practitioner certification program. It also operates on a voluntary basis, and its purpose is to ascertain that applicant facilities are staffed, equipped, and organized to provide competent patient service.

The accrediting of patient care facilities is a continuing process.

- **EDUCATIONAL INSTITUTION ACCREDITATION**

The Association and The American Board for Certification have historically supported the development of formal educational opportunities for the orthotic-prosthetic profession, including assisting in the organizing of curricula, providing instructors, and so on. However, no formal accrediting procedure was created.

With the impact of expanding public concern about patient care delivery, many educational institutions at various levels began to express interest in offering orthotic-prosthetic courses or curricula. Therefore, in 1970, the Association and The American Board, utilizing the resources of all related private and public agencies, developed Essentials for the Education of Orthotists and Prosthetists at the technician, assistant and practitioner levels.

The principal purpose of the Essentials are (1) to assure that the appropriate instructional capability (environment, staff, etc.) is provided, and (2) to assure that technical content is current and uniform among all teaching institutions.

Reasons for Selection

The existing practitioner certification and facility accreditation processes were selected (in 1948) in consultation with the U.S. Department of Justice and the Federal Trade Commission. Their form was motivated by the then lack of intense consumer protection attitudes, as now exist, and the reluctance of the profession to voluntarily seek government regulation through state licensing.

The educational institution accrediting process was selected on the advice of persons who were experienced in that aspect of allied health educational work.

Criteria

- Practitioner Certification (See THE BOOK OF RULES, page 9)
- Facility Accreditation (See THE BOOK OF RULES, page 30)
- Educational Institution Accreditation (See The Essentials of the Education of Orthotists and Prosthetists)

Purposes

It is believed that the operation of the practitioner certification and facility accreditation programs has stimulated the public recognition of the practice of orthotics and prosthetics as an allied health profession rather than a vocational craft.

This belief is based on the fact that an increasing number of related practitioners (physicians, etc.) and organizations and agencies (various State health and welfare agencies, the Veterans Administration, etc.) are requiring that only practitioners and facilities certified and accredited by The American Board for Certification provide service to their beneficiaries and clients. Presumably, this requirement is premised on the concept that certification and accreditation signify demonstration of an acceptable level of competency.

Problems

No particular problems were identified in initially implementing the programs or in maintaining them.

Planned Improvements

The practitioner certification and facility accreditation programs have been constantly upgraded during their history. The concepts set out in the December, 1970 edition of **THE BOOK OF RULES**, and their implementing procedures (the nature, content, etc., of the practitioner examination and facility accreditation processes) represent the refinements developed since the last edition issued in April, 1967.

The upgrading activity is expected to continue. However, future implementation is conceived as taking a different route. Both the Association and the Board are convinced that they must advocate a uniform State licensure statute, and that proposal is now being drafted. Its objective will be, aside from attempting to insure uniformity of legislation to the maximum possible extent, to incorporate the present voluntary programs for administration by The American Board for Certification as the authorized representative of the various States.

AMERICAN PHYSICAL THERAPY ASSOCIATION

Type of Credential Process

With the passage of a physical therapy practice act in Texas during its 1971 legislative session, establishment of physical therapy practice acts in all of the states, the District of Columbia, Puerto Rico, and the Virgin Islands was complete.

Reasons for Selection

The process of gaining licensure in the respective states has occurred over an approximate 30-year period. The principal reason for choosing this route of credentialing was the failure of a certification process that had preexisted. Any credentialing process should ensure the public of a reasonable standard of proficiency of the credentialed person, deter those not qualified from presenting themselves as qualified, and define a legally supported description of the scope of activity of the credentialed person. It was believed that uniform state licensure would accomplish these purposes where the previously existing certification process had not.

Additionally, it was hoped that licensure would deter physician utilization of unqualified individuals to provide physical therapy services.

Criteria

The principal criteria for becoming licensed are 1) graduation from a curriculum in physical therapy accredited by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association and 2) successful completion of a comprehensive examination.

With few exceptions, these two criteria exist in all of the practice acts throughout the country. Notable exception to this process is that several states will license persons who have demonstrated to the satisfaction of the state that they have attained equivalent education and/or experience proving proficiency equal to the physical therapist educated in an accredited program. The examination is required of this group. The examination has been standardized in all but four states.

Purposes

Several purposes are served by the process:

- Standardization of the credential requirements
- Establishment of a reasonable standard for identification of qualified physical therapists
- Establishment of a legal definition of the scope of activity of a physical therapist
- Establishment of a national standard and at the same time protection of the integrity of the standards of the respective states

Problems

In addition to those problems inherent in any legislative process, there has been occasional resistance from organized medicine and from nonqualified persons who were opposed to the establishment of standards for education or for proficiency.

Moreover, unless mandatory licensure has been passed in the state, physicians can use *anyone* to function in *any* capacity in their offices—and are, therefore,

able to side-step standards of competence which licensure laws attempt to set forth. Mainly because of resistance of organized medicine, few states presently have mandatory laws for physical therapy practice.

Planned Improvements

The barriers to implementation are those found under Problems above. The principal improvements envisioned include greater standardization between states of the requirements and processes for licensure and provision within the practice act for the optimum utilization by physical therapists of the physical therapist assistants. The end product of these improvements should provide reasonable standardization of criteria among all states, lateral mobility for the physical therapist between states, and standardization of the scope of service. It is further envisioned that means to measure continuing competence would become an inherent part of this credentialing process.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS

Type of Credential Process

A Board of Registry of Laboratory Technician was established in 1928 by the American Society of Clinical Pathologists (ASCP). For a time this Board certified two general categories of laboratory personnel—laboratory technicians and medical technologists. In 1936 it was decided to drop the term "laboratory technician" and certify all generalists as "medical technologist". Accordingly, the name of the registry was changed to the Board of Registry of Medical Technologists.

In 1949 the Board of Registry was restructured to form a joint sponsorship of the Board of Registry by the American Society of Medical Technologists and the American Society of Clinical Pathologists with representatives elected from each society having full voting privileges. At present the Board of Registry is composed of five representatives of the ASMT and six representatives of the ASCP. However, the latter organization maintains that the "Registry" is its exclusive property and, immediately prior to the current litigation, ASCP proposed revisions of its Constitution and Bylaws to eliminate this joint sponsorship of the Board.

Within the past five years two other generalist certifications—certified laboratory assistant and medical laboratory technician—have been developed to define other levels of personnel employed in today's clinical laboratory. In addition, the Board of Registry has developed categorical certification in blood banking, chemistry, microbiology, hematology, nuclear medicine technology, cytotechnology and histologic technique. A third group, specialist certification, includes hematology, microbiology, chemistry and cytotechnology.

Reasons for Selection

It is obvious from the history of the Board of Registry that voluntary non-governmental certification was not initially selected by ASMT, which was established in 1932, several years after the Board of Registry. However, the Society for many years has actively endorsed national non-governmental credentialing measures as the most flexible and effective approach to standardized criteria for laboratory personnel. On the positive side, national voluntary certification provides:

- Uniformity of standards for all areas of the country;
- No barriers to geographic mobility; horizontal or vertical mobility;
- Flexibility to changes in education, social and scientific developments;
- Direct responsibility to the profession to maintain standards or develop innovations;
- Centralized and economic means for development of examinations and administrative processes.

Until 1966, ASMT had maintained an adiaphorous policy on governmental credentialing systems, neither encouraging nor discouraging affiliated state societies from seeking the enactment of such measures. However, policies adopted by the ASMT House of Delegates in 1966 and 1967, defined a position favorable to licensure, and measures to encourage affiliated societies to interest state legislatures in governmental regulation of the field. Therefore, the Society has developed guidelines, and a guide bill, and provides consultants to those societies requesting such aid.

This change in policy on the part of ASMT was the result of many forces. Medicare, with its regulations for independent laboratories, has served as a cogent

example of how governmental regulation can serve to effect uniform standards and quality services. However, such regulations, and the licensure of laboratories in interstate commerce (Clinical Laboratory Improvement Act of 1967) do not apply to all laboratories or all persons engaged in the practice of medical technology. While voluntary certification may be an effective means of maintaining standards in other health fields, in the medical laboratory field it has not effectively controlled the employment of nonqualified individuals, or the placement of those with little education and experience in supervisory positions. Thus, the patient-public has no assurance of quality in laboratory services. Mandatory state licensure appears to be the only avenue presently open to maintain standards in the public interest.

Criteria

MEDICAL TECHNOLOGIST, MT(ASCP)

- Completion of a four-year college or university program including a clinical education component approved by the Council on Medical Education of the AMA. Such a program should be conducted so that the baccalaureate degree requirements of the academic institution are fulfilled (as of 1972 it will be necessary that the program culminate in a baccalaureate degree). Requirements in the pre-clinical preparation include sixteen semester hours of chemistry, sixteen semester hours of biological science, and one semester of mathematics.
- An individual is also eligible for the examination if he possesses a baccalaureate degree with the above courses and five years of experience in the clinical laboratory.
- The certifying examination is a 200 multiple choice examination which includes questions in the major areas of medical technology. Successful completion of the examination is contingent upon an individual exceeding a score of one standard deviation below the mean for that particular examination. The participants receive information as to their performance on each section of the examination, the mean score, and one standard deviation of all candidates, the T-score in each section, and their total performance in the examination.

MEDICAL LABORATORY TECHNICIAN—MLT(ASCP)

Candidates for this certification usually possess an associate degree. Essentials for educational programs for medical laboratory technicians have been approved by the ASMT House of Delegates and the ASCP and will be submitted to the AMA House of Delegates for consideration. Accreditation of educational programs will be initiated subsequent to AMA adoption of essentials. Certifying examinations were given in 1970 and subsequent examinations have been given to those individuals who possess an associate degree of 60 semester hours from an accredited institution and one of the following:

- Is a certified laboratory assistant or
- Has graduated from a 12-month military medical laboratory program or
- Has had five years of experience in an acceptable laboratory.

An individual may be admitted to this examination who has completed an integrated program of academic and structured clinical education leading to an associate degree from an accredited institution.

CERTIFIED LABORATORY ASSISTANT, CLA

- Must have graduated from high school and successfully completed an educational program approved by the AMA.
- Successful performance on a written examination.

Purposes

The purpose of the national certification process is to establish criteria for competence of practitioners in the medical laboratory field and is purported to be a guarantee of quality performance to a potential employer. However, concern as to quality recently has been expressed due to the lowering of the pass-fail mark obtained by examinees.

While the present certification criteria provide a flexible approach including experience and alternate educational routes, most people follow the conventional route of education and training. It is also interesting to note, that relatively few people have applied for categorical certification, the generalist certification providing the most opportunities for jobs and advancement.

In the experience of the ASMT, shortages in laboratory personnel, if in fact they exist, are not due to inflexible or unrealistic certification standards. Rather, many possible students and also those educated in the field are lost from the profession, due to a long history of low salaries, poor personnel practices, and a depression of role and opportunities.

Problems

Implementation of the voluntary certification process for medical laboratory personnel presents complex problems relating to both certification and accreditation of educational programs:

- There are nearly 800 AMA-accredited programs for medical technologists alone. These present a great variation, not only in student capacity, but also in the capability of schools to provide a balanced curriculum and quality educational environment. Since the certification examination is graded on a curve, a relatively low passing mark sometimes results. Also, as now designed and graded, an examinee could fail to answer correctly all questions on a subject, such as chemistry, hematology, etc., and still pass the examination. It is therefore questionable whether the approximately 84% passing each generalist examination should in fact be certified to practice.
- Though two task forces have been held during the past five years to develop items for the examination pool, in view of changing technology a task force on a continuing basis to maintain an adequate pool is critically needed. Additionally, the development of special categories of questions which would be optional components of a basic examination in the area of radioisotopes, instrumentation, management, education, etc., are needed.
- Another problem is the trend toward creation of certification in special categories before there is an evaluation of need for same or a standardized curriculum which creates additional utilization and mobility problems.
- Until 1970, persons certified by the Board of Registry were required to register annually (usually termed "recertification"). Failure to do so for three consecutive years resulted in their names being removed from the Registry list. A second reason for removal by the Board of Registry was

employment in a laboratory operated by a non-physician director. This type of action, in effect invalidating credentials, came under attack in the courts of New Jersey. In a decision rendered in 1968 by the Supreme Court of New Jersey in *Higgins vs. ASCP*, the Court held that so-called "standards of conduct" violated the policy of that State, which licenses non-physician directors.

The Board of Registry's Code of Ethics and Standards of Conduct as well as practices of pathology groups relating to possible restriction on ownership and operation of laboratories or employment, area-wide uniform fee schedules, etc. also came under legal scrutiny in October 1965 when the U.S. Department of Justice filed a Civil Investigative Demand against ASMT, ASCP, and the College of American Pathologists (CAP), respectively. The Demand was dismissed against ASMT in 1967 but led to a Civil Anti-Trust action against the CAP that culminated in a Consent Decree being entered in July 1969. During the negotiation of the CAP Anti-Trust suit the U.S. Department of Justice also informed the Board of Registry that certain reregistration policies were objectionable under the Anti-Trust laws. As a result, the Board of Registry no longer requires annual registration or sets employment "standards".

- Multiplicity of registries for medical laboratory personnel presents a confused picture to the public as well as to the potential employer. There are at least three professional organizations maintaining certification boards for generalists, while categorical certification has been developed by additional organizations. Thus, there is much duplication of effort and costs.

Planned Improvements

- Utilizing appropriate consultants and advisors, a professional organization should be responsible and accountable for the development and maintenance of proper standards for the certification of the members of its profession. ASMT has been placed in the untenable position of having the certification of its members under the control of another profession.
- In 1970 ASMT prepared a plan to coordinate certification and bring under one umbrella the functions of the various existing registries. In view of the present climate relating to the credentialing process for all health professions, nothing positive has been accomplished.
- ASMT has developed and submitted to the Division of Allied Health Manpower (NIH) a contract for curriculum evaluation and subsequent reform. The next step would be reevaluation of the examination.
- ASMT submitted to the Division of Allied Health Manpower (NIH) a contract proposal to hold a conference for describing the utilization relative value potential and merits of proficiency and equivalency examinations currently under development. Reportedly, such a contract on these matters has been awarded to a state hospital association.
- A proposal for a study of the utilization of medical laboratory personnel has in the past been pursued as a cooperative endeavor with ASCP. More recently a proposal was prepared by the ASMT Education and Research Fund, Inc. In light of recent interest in expanded utilization of health manpower to meet critical manpower needs, a like proposal on utilization of laboratory personnel is currently under review by ASMT.

- In 1968 the ASMT House of Delegates requested investigation of possible requirements for continuing education or other processes as an indication of current competence. While a voluntary self-assessment program has been initiated and distributed to the entire profession as a service of ASMT, further study of this procedure as a mechanism indicating current competence is necessary. Of the over 80,000 certified as medical technologists by the Board of Registry, it is estimated that about 40,000 are active in the field. Thus, the very logistics for current evaluation of certification on the basis of educational or other like requirements presents a formidable, and no doubt, expensive undertaking. A number of potential alternatives should be explored.

AMERICAN SOCIETY OF RADIOLOGIC TECHNOLOGISTS

The American Society of Radiologic Technologists and the American College of Radiology cosponsor the certifying body for the technologies relating to Radiology: X-Ray, Nuclear Medicine, and Radiation Therapy. This agency, the American Registry of Radiologic Technologists, is a separate corporate body organized in 1922 to examine and certify candidates based on established standards of education and training.

This corporation is composed of eight trustees and an administrative staff. Four of the trustees are appointees from The American Society of Radiologic Technologists and four from the American College of Radiology. Each trustee serves a four year term, and each organization appoints a successor for their retiring representative.

The operation of the Registry is flexible but based on bylaws approved by both sponsoring bodies. Any changes or amendments in these bylaws must be approved by the governing body of each sponsoring organization.

Eligibility requirements for candidates to the examinations are defined in the bylaws. (See Appendix I.) Examinations are developed by the Trustees, with consultants of their choosing, based on AMA approved Essentials in the respective categories. Successful candidates who meet all referable eligibility criteria are certified as Registered Technologists (R.T., ARRT) in either X-Ray Technology, Nuclear Medicine Technology, or Radiation Therapy Technology.

Voluntary certification for X-ray technologists was established as a means of recognition for the qualified technologist. Since responsibility for the patient was ultimately that of the physician, legislative measures were not considered at the outset. National examinations, based on national standards, appeared preferable, then and now, to nonuniform measures of credentialing of personnel.

The American Registry is the only certifying agency for Radiologic Technology recognized by organized medicine. Despite physician and technology support of the Registry, which has improved its prestige, more than 50% of the operators of ionizing radiation equipment (used for medical purposes) are not Registered Technologists. For several years there has been mounting support for legislative processes to implement mandatory requirements for technologists, and most particularly X-ray technologists.

Three states (New York, New Jersey, and California) and the Commonwealth of Puerto Rico have such laws. Except for reciprocity with these states there is no legal recognition of certification by the A.R.R.T.

A written multiple choice instrument is used by the American Registry for examination. The same examination is used nationally and the examinations are administered on or about the same dates throughout the country. A written examination is used because it is the most objective and expedient method of administering an examination based on a uniform educational standard to nearly 6,000 examinees annually. A number of years ago, a semi-practical examination was also required. Candidates under this system were required to submit radiographs of each part of the body for judgment by the Executive Director of the American Registry. As the number of candidates increased this system became difficult to manage. Additionally, the objectivity and validity of such a method of examination is questionable.

While the Society supports the purposes for which the Registry was established, there are problems to be resolved:

- The testing device currently places too much emphasis on *quantity* of successful candidates rather than quality.
- Frequently the Registry Board is unresponsive to the organization representing the profession it serves.
- Administrative problems include examination security for an instrument so broadly distributed; development of valid and reliable examinations; adequate accountability to the sponsoring bodies without jeopardy to the autonomy of the examining body.

More nebulous difficulties are related to the pressures from a number of agencies and individuals who seek exceptions to the eligibility requirements for the candidates in whom they have vested interest. The certificate of Registration is not a permit for employment nor a proficiency examination. Rather, it is verification that the holder possesses the competencies the educational program was designed to provide. Nonselective admission to the Registry examination would jeopardize the intent of its establishment.

Increasing demands for health care have focused our attention on the need for equivalency testing. A cooperative effort with the Registry has been proposed.

AMERICAN SPEECH AND HEARING ASSOCIATION

The American Speech and Hearing Association (ASHA) has maintained a voluntary certification program since 1952. However, from the Association's founding in 1925, until 1952, members were designated as either "Clinical" or "Professional" depending on their level of training and experience.

ASHA certification is designated as the Certificate of Clinical Competence (CCC) and is awarded in either Speech Pathology (SP) or Audiology (A). As of August 15, 1971, 8,948 speech pathologists and 1,782 audiologists of the 13,741 ASHA members were certified. 830 members hold certification in both areas.

Membership in the Association, which requires the master's degree or its equivalent, is necessary for certification. Although the ASHA Code of Ethics stipulates that members who provide clinical services in speech pathology and audiology must hold appropriate certification, certification is not necessary for Association membership unless such services are provided. ASHA will also evaluate the credentials of non-members who are required to meet certification standards to participate in certain state and federal programs.

In order to achieve certification, applicants must have successfully completed:

- 60 semester hours of appropriately distributed academic course work, of which at least 30 semester hours must be acceptable for graduate credit;
- 275 clock hours of appropriately supervised and distributed clinical contact training, of which at least 150 must be at the graduate level;
- at least 9 months of appropriately supervised full-time professional clinical experience; and,
- a national examination.

NATIONAL ENVIRONMENTAL HEALTH ASSOCIATION

The environmental sanitarian uses two credential processes: Registration and Certification.

Registration

- *Registration*, established by legislation in 39 states, is the major process used to give credence to the professional sanitarian. Registration is voluntary in 30 of these states and mandatory for continued employment in the 9 other states. The National Environmental Health Association (formerly National Sanitarians' Association) has a registration program for sanitarians employed in states that do not have a registration program.

The registration process for sanitarians was first established by the National Environmental Health Association on a voluntary basis to define and give recognition to professionally qualified sanitarians. In the early 1950's, emphasis was switched from registration through a board in the professional organization to registration established by state legislation. The legal provision for registration was in keeping with that provided for other professional groups that the sanitarian works with or relates to in the engineering and health fields. There is a history of persons representing themselves as qualified sanitarians that were not qualified, or of health agencies employing unqualified persons in the sanitarian classification. These practices are eliminated through registration established by legislative action.

The registration acts in the 39 states are remarkably similar, primarily because of the guidance provided through a model registration act developed by the Sanitarians' Joint Council. The essential provisions in the registration acts include definition of a sanitarian, restrict use of the title "sanitarian", establish minimum education and work experience to qualify for registration, establish an annual fee for registration, define terms for reciprocity between states, and provide for a board to supervise or regulate the registration program. The education qualifications specified in all but 11 states require graduation from a four-year course in environmental health. In states where environmental health curricula are not offered, 30 semester hours in environmental health-related science may be substituted. Ten states require no previous experience in environmental health to become registered, while the remainder of the states require one or two years' experience. In states where registration is mandatory, a person normally has six months to one year after his initial employment to become registered. In all states except two an examination, either written or oral, or both, is required to become registered. The majority of states use the Professional Examination Service of the American Public Health Association, which has developed a sanitarian's registration examination. During the first year after passage, all sanitarian registration acts have provided for persons employed in sanitarian positions to become registered as sanitarians without meeting the educational or examination requirements established by the act.

One purpose of the registration is to assure the technical competence of persons functioning in a critical area. This is accomplished by restricting the use of the title "sanitarian" to only those persons registered by the state registration board. Persons not meeting the registration requirements can be employed in 30 of the states, but not as "sanitarians". This has upgraded the quality of personnel employed by local health agencies in two ways. The academic institutions have developed or have improved existing programs for the training of professional sanitarians, and the employers of sanitarians have had a standard to guide them in employing competent personnel.

The chief problem encountered in implementing the registration act centers on the variation among acts and establishing reciprocity which must be negotiated with each state registration board.

The planned improvements in the areas of registration include establishing mandatory registration in place of voluntary registration, establishing reciprocity among more states, and seeking revision of present registration laws which are behind current standards. All three of these problems are being worked on by the Registration Council within the National Environmental Health Association. This council is made up of representatives from each state registration board. The NEHA faces a shortage of professional staff that can give assistance to the Registration Council in implementing the needed improvements.

Certification

- The second credential process utilized by sanitarians is *certification* through the American Intersociety Academy for Certification of Sanitarians. This Intersociety Academy was developed through the cooperation of the three major organizations which represent the sanitarian, National Environmental Health Association; International Association of Milk, Food, and Environmental Sanitarians; and Section on Environment, American Public Health Association. The certification program is dedicated to giving recognition to the sanitarian of high quality that has performed in an outstanding manner.

The certification process was selected because it is an accepted method of giving recognition to distinguished professionals. It is a higher form of recognition than provided through registration, which established the basic academic and experience requirements for the profession.

The requirements for becoming a diplomate are: he must be a registered sanitarian; possess a master's or higher degree in public health or environmental health; must have at least nine years' experience, out of which a minimum of two years must be in a position of responsibility for administration, management, supervision, research, or teaching; provide acceptable references; and successfully complete written and oral examinations in any one of several specialty areas.

The purpose served by the process of certification is one of giving recognition to a select group within the professional category of the sanitarian. It is anticipated that certification will motivate sanitarians to achieve. Identification of top quality persons through certification will be valuable to others seeking out these people.

The problems encountered in implementing the certification program have been essentially mechanical. The review process and final acceptance of a candidate for certification is laborious because of the detailed review of a person's qualifications and contributions to the field of environmental health. Once the Academy was formed and the initial group of sanitarians certified, the problems of reviewing new applicants has reduced to a point where the work can be reasonably handled by committees within the council.

At this point there are no planned revisions in the certifying process or in the standards for certification.

CHAPTER IV—CONFERENCE RECOMMENDATIONS

Conference participants were divided into eight multi-disciplinary Task Groups to discuss the topics outlined for the Conference. The discussion periods engendered extensive exchange of information and problems on certification and related areas of common interest among the professions. Reports of the Task Groups, prepared by the Moderators for use by the Planning Committee, are included in Appendix C.

The Task Groups emphasized that direct input from each profession is essential and should be a procedural approach of the study. It was further stated that priorities for implementation of the recommendations should be indicated and that a phased plan for implementation should be developed.

The following recommendations were synthesized by the Planning Committee from the reports of the Task Groups.

Need and Feasibility for a Study of Certification in Allied Health Professions*:

The conference participants indicated that a study of certification in the allied health professions within the scope and focus delineated in the discussions was deemed necessary and feasible. It was further indicated that a study should be initiated promptly.

Scope of the Study:

The scope of study reflected by the majority of the conference participants was that:

- it should include all allied health professions, and
- the primary focus of the study should be on certification; licensure, registration and accreditation should be considered secondarily as they relate to certification.

* The meaning of the term "allied health" varied among the conference participants. This variability was identified as a problem which should be considered during the conduct of the study and a definition developed for use in connection with the study. The term as utilized in this report reflects a broad and flexible definition of allied health.

General Objective of the Study:

The objective of the study is to investigate major areas of concern delineated and to develop recommendations related to the improvement of certification in the allied health professions.

Organization of the Study:*Sponsor of the Study—*

Six of the eight Task Groups recommended an organized group of the allied health professions as appropriate sponsors for the study and existing organized allied health groups were identified. Therefore, sponsorship by the ASAHP Council on Health Organizations and/or the Coalition of Independent Health Professions with participation by non-member allied health professions reflects the general thinking of the Task Groups.

The Planning Committee, consistent with expressions from some of the Task Groups, suggests the following functions for sponsors:

- select a steering committee for the study;
- select and/or approve the director of the study;
- be the fiscal agent for the contract and accountable to the funding agency for the implementation of the contract.

Steering Committee of the Study—

The conference participants recommended that the Planning Committee for the Invitational Conference on Certification (September 7-10, 1971) be considered by the sponsors for membership on the Steering Committee of the proposed study.

The Planning Committee, consistent with expressions from some of the Task Groups, suggests the following functions for the Steering Committee:

- draft the plan for the study;
- nominate the members of a commission to conduct the study;
- recommend an individual(s) for the director of the study;
- upon the initiation of the study, function in an advisory capacity as deemed desirable by the director of the study.

Commission of the Study—

It was recommended that a Study Commission be formed, that it be of an independent nature with significant representation of allied health professions, and that advisory groups be utilized as deemed appropriate.

The Planning Committee, consistent with expressions from some of the Task Groups, suggests the following functions for the Study Commission:

- be responsible for the conduct of the study;
- be responsible for the final recommendations of the study.

Funding of the Study—

Fund from private sources was the preference stated; alternatives suggested were other appropriate sources including federal funds.

Areas of Study:

The varied opinions of the conference participants in identifying the professions encompassed by the term "allied health" was recognized as a problem. Therefore, the participants strongly urged that a definition of

allied health be developed in the progress of the study, and that broad acceptance of this definition be sought. The interrelationship of certification with other credentialing mechanisms and accreditation was recognized; any study on certification should include its relevance to these mechanisms.

The areas of study enumerated by the Task Groups have been condensed and grouped into six categories by the Planning Committee:

Certification Purposes and Policies

- Common and unique purposes for certification among professions;
- Common and unique policies of certification among professions;
- Rationale for the addition or deletion of certification for health occupations;
- Glossary of common terminology.

Process of Establishing Standards for Certification

- Knowledge and skills required for initial and continuing competence in each profession:
 - general academic base or alternatives
 - specialized job-related knowledge and skills;
- Feasibility and use of successful completion of an accredited program as the certification mechanism;
- Feasibility and study of alternative methods of achieving certification;
- Common and unique internal forces within the professions that influence the establishment of standards;
- Feasibility of and mechanisms for permitting career mobility.

Certification Credibility and Accountability

- Validity of certifying criteria in relation to competency for quality health care;
- Reliability, validity and security of measuring instruments;
- Composition, structure, function and control of standard setting and/or certifying agency(ies);
- Appropriateness and acceptability of the certifying body to the professionals, the employers and the public;
- Enforcement of standards in relation to the consumer and the profession.

Manpower in Relation to Certification

- Supply and distribution of certified and uncertified health personnel;
- Utilization of certified and uncertified health personnel;
- Underutilization and overtraining of health personnel;
- Consequence of enforcement of standards on availability of services.

Economics of Certification

- Potential for conjoint administrative mechanisms;
- Feasibility of and mechanisms for common certification procedures;
- Cost effectiveness of certified and uncertified personnel on the delivery of health services;

- Salary differences between certified and uncertified personnel, including relationship to costs of education.

External Forces Related to Certification

- Accreditation;
- Licensure;
- Registration;
- Academic requirements;
- Special interest groups including organized medicine, dentistry, and government;
- Hiring practices of employers;
- Economic and status needs of the practitioner;
- Third party payment for services;
- Unionization;
- Legality of mandatory association membership;
- Logistics of examination administration.

Credentialing of allied health professions faculty in formal educational programs was also recognized as a topic for consideration.

APPENDIX A—GLOSSARY

The following definitions are stated for utilization at this Conference for the purpose of clarification of content during the discussion periods.

Credentialing is the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field.

Accreditation is the process by which an agency or an organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. Accreditation shall apply only to institutions and programs.

Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure is the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or to use a particular title, or grants permission to institutions to perform specified functions.

Registration is the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

Qualifying examination is a criterion for measuring an individual's ability to meet a predetermined standard.

Equivalency testing is the comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

Challenge examination is equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

Proficiency testing assesses technical knowledge and skills related to the performance requirements of a specific job; such knowledge and skills may have been acquired through formal or informal means.

Note: The meaning of the term "allied health" varied among the conference participants. The term as used in this report reflects a broad and flexible definition.

APPENDIX B—REFERENCES

REFERENCE NUMBERS

1— 30	Certification
31— 62	Licensure
63— 80	Accreditation
81— 95	Education, General
96—121	Education, Allied Health Professions
122—132	Education, Continuing
133—148	Examinations
149—180	Manpower, General
181—205	Manpower, Utilization

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APPENDIX C—TASK GROUP REPORTS

TASK GROUP I

In the interest of providing more effective health care services to the public and assuring minimum standards to permit optimal opportunities for entry into the allied health professions, it is proposed that a study of certification and licensing procedures, and the role of accreditation in both processes, be undertaken, to include:

- Relationship of credentialing procedures to the public needs
- Relationship of internal and external influences on establishing minimum standards for entry into the allied health professions including:
 - formal education process
 - alternative process
- Relationship of certification to competence
 - at the time of certification
 - later
- Relationship of maintaining licensure, certification and registration to competence
- Means of determining competence
- Economics of allied health
 - salary differences in credentialed and non-credentialed workers
 - career opportunities of both groups
 - compare physician and non-physician salaries
 - cost of education for the credentialed allied health worker in relation to the lifetime income
- The possibility of enforcement of the certification process
- Relationship of the non-credentialed allied health worker to the credentialed allied health worker
- Composition, structure and function of credentialing boards including exploration of means to achieve efficiency, economy, etc.
- Relationship of supply, demand and distribution

Low priority—investigation of credentialing of allied health professions faculty in formal educational settings—

Recommend that the study be conducted by the ASAHP (if the name is altered to be more representative of all allied health, i.e., omit the reference to "Schools of")

TASK GROUP II

This Task Force saw the overall objective as being that of assuring quality and comprehensive health care and services.

Recommendation I

That a study be initiated on credentialing.

Scope:

- That the study be on the current status, nature and scope of present credentialing practices and needs of *all* health disciplines.

Method:

- That it be mandatory that each health discipline be given equal opportunity to provide input.
- That a group such as the National Health Council or a similarly constituted group be asked to activate the study by an independent commission accountable to the public.
- That the study be initiated in the near future.
- That private funding be sought for this study.

Recommendation II

That each discipline seek the commitment of its official organization to the study; to collaborate with the study and provide input to the study; to inform its membership of its objectives and purposes and to seek membership support and involvement.

Area of Study:

- Alternate routes for credentialing
- Need for close articulation between disciplines, with education and with employers
- Need for commonality in semantics so labels indicate equal levels among professions

Scope of Study by Priority:

- To determine current credentialing practices of all health disciplines
- To evaluate purposes and effectiveness of credentialing for all health disciplines
- To identify social and economic implications of all health disciplines
- To identify principles and policies and the administrative processes of all health disciplines
- To develop recommendations based on the findings to ensure quality health care and services

TASK GROUP III

Consensus is that a study of certification should be undertaken. Such a study should consider certification in relation to accreditation and perhaps licensing.

Sponsored by: An independent and objective group with equal support and representation of all allied health groups.

Multiple sponsorship, possibly including government.

If government is involved, it is suggested the Planning Committee of this conference be used as an advisory group in planning the certification study.

Objectives: Based on recommendations coming out of all reports of this conference.

Recommendations of the study should be presented in priority format with step-by-step procedure for implementation.

Problems or areas of study:

Who needs to be certified

Certification should, if possible, incorporate validity of continuing competency

Inequities to individuals (take exam with passing score which varies according to manpower needs)

Security of exam

Validity and reliability of exam

Composition and control of certifying boards

Need for consumer and student representation on boards

Consider:

- Convenient access to place of certifying exam
- Length of exam (expense involved if held for two days)
- Costs
- Possibilities of all health professions sharing resources

Criteria for certification include non-traditional educational experience

Problem of keeping certification criteria up-to-date in face of continually expanding knowledge and practice

Need for certification to gain recognition and support from employers and public

Problem of new professions or new combinations of tasks from two or more professions. Who decides on certification criteria and who certifies?

TASK GROUP IV

Preamble

Scope:

That no further study of the basic mechanics of certification be pursued with the exception of up-dating currently-available baseline data.

Methodology:

That the allied health professions provide significant input into the study.

Action Recommendations

Additional Comments:

- That there be formed a "coalition" of allied health professions to represent common interests and concerns.
- That each professional association and registry review its certification process to ensure that it represents current consumer needs.

Proposed Study Problems (in priority order)

- Common definition of "allied health".
- Validity of certification examinations:
 - To measure clinical competence
 - To measure relevance to current employment demands and needs
 - Significance of and methodology of setting of pass-fail criteria
 - Identification of responsibility for assuring that exams are relevant

- Ability of certification process (as a part of credentialing) to protect the consumer:
 - Extent to which the process currently protects the consumer
 - Extent to which certification *should* protect the consumer
 - How can this be accomplished?
- Possible ways by which professional organizations can correct substandard practices in training, accreditation, and certification including continuing education.
- Problem of overtraining and underutilization of allied health professionals. (Many are prohibited from functioning to the maximum of their ability and training by the limitations of the job description.)
- Relationship of certification to accreditation:
 - Part of or separate activity
 - Performed by one body (same) or by separate organizations
- Legality (and desirability) of requiring association membership for initial and/or renewed certification.
- Potential effect of unionization on allied health controlled certification.
- Feasibility of pool of all questions from common content areas; sharing of examination techniques and study materials.
- Common terminology in identification (designation) of credentials.
- Secretive nature of certification and accreditation (within the associations vis-a-vis those seeking certification or accreditation and the membership in general.)

Additional Comments

- Concerns expressed by group regarding physician's associate with regard to their certification requirements, function, licensure, relationship to and differentiation from medical assistants.
- Concern expressed regarding foreign medical graduates and inability to utilize their skills as certified health workers (e.g., a foreign radiologist qualifying as a registered radiologic technologist) while they prepare to write E.C.F.M.G.'s (or even if they don't plan to write them).
Also, inability to use foreign medical graduates who could qualify except for language barrier—why not a license limiting practice to a Spanish neighborhood for a Spanish-speaking doctor?

TASK GROUP V

The Task Group recommends that a study of credentialing in the allied health professions be developed and carried out by an appropriate group of organized allied health professions with the Planning Committee for this Invitational Conference (on Certification in Allied Health Professions, held Sept. 7-10, 1971) constituting the initial nucleus for this project. This committee shall seek appropriate financial support.

Scope:

The study shall include all allied health professions as so identified by the the committee. The primary focus of this study shall be on certification. Licensure, registration and accreditation shall be considered secondarily as they relate to certification. Entry levels only shall be studied.

Problems to be Studied

- Can "core certification" procedures be determined to cover groups of professions
- The possibility of conjoint administrative mechanisms should be studied—
- Can the extent to which *general* academic background requirements are appropriate for certification be determined—
- The study should ascertain if a more appropriate use of manpower and/or an enlarged supply of manpower can be accomplished through modifications in credentialing—
- Determine whether minimal standards yield the best patient care—
- The mechanisms of certification must be examined—
- Develop "rationale" for the addition or deletion of certification for health occupations—
- Investigate methods of extending "professional recognition" in exceptional cases when certification is not appropriate or possible.

It may be appropriate to add that this group felt most strongly the need for an active organization of the allied health professions. This organization should be the recognized voice of the professions in Washington and should have frequent meetings of representatives to review the professional mechanisms of accreditation and certification. It was felt that ASAHP could not be this effective voice under its present constitutional structure.

TASK GROUP VI

Group VI felt that the Invitational Conference, by bringing together representatives of allied health professions to discuss common concerns regarding certification, had been extremely productive.

The following advantages of certification were identified:

- Protects the patient
- Establishes level of minimal competency
- Identifies parameters of practice

Certain limitations were also described:

- Not mandatory
- No mechanism for enforcement
- Physician dominance in some groups

Conclusion

The Group felt that a study of certification in the allied health professions was both needed and feasible.

Objective of Study

To identify principles that could be used by all allied health professions in the development and refinement of their certification systems.

The study must be interrelated with all segments of education and health care delivery.

Areas of Study

All allied health professions should be encompassed in the study.

Standards

- When is credentialing necessary?
- When is certification the most appropriate means of credentialing? Are these affected by outside forces?
- Who develops standards?
- Identify areas of common knowledge or skill or both.

Methodology for Certification

- Entry system (single or multiple ways to qualify for certification).
- Tools used (written examination, practical, other—their validity and reliability in demonstrating competence).
- Validity and feasibility of consumer participation.

Enforcement

- What are implications of taking uncertified out of system? Leaving in?
- How and who can enforce?

Recommendations

- The group responsible for conducting the study should be representative of the professional associations of the occupations involved in allied health.
- The study must not be constrained by organized medicine, dentistry, or by government.

TASK GROUP VII

Members of Task Group VII prepared the following consensus and proposal after their discussion of the Conference agenda.

The majority of the members recognized the need for a study of certification and favored undertaking a study. A minority of the members did not favor a study of certification of health personnel. All members of the group participated in the development of the scope, objectives and related topics for a study.

Scope

The scope of a study of certification must include consideration of licensure, registration, and accreditation as they relate to certification. (See Glossary in Source Book for the Conference).

Objectives

- A study of certification in the health professions shall be conducted to
- describe an orderly process for certification of health personnel that will identify
 - core elements (i.e., elements of certification common to all or most health professions),
 - elements that are necessarily appropriate for individual professions (i.e., unique to a profession),
 - mechanisms in the certification process that will permit career mobility;
 - determine the feasibility of using an initial certification mechanism of successful completion of an accredited program that produces a job-ready person (four years, two years, clinical study, vocational programs, military programs, etc.);

- determine an alternate mechanism that will provide certification of persons who have not completed formal education routes;
- determine mechanisms for evaluating and maintaining the competence of certified health personnel, considering the potential of
 - re-examination (must consider the frequency of examining and type of examinations suitable for the purpose),
 - continuing education,
 - peer review,
 - prepare a statement of the purpose of certification as a mechanism to provide protection of the public and the practitioner, and to ensure quality health care.

The priorities assigned to these objectives in the development of a study should be based on the logic of research design. The urgency of supplying manpower or accommodating existing manpower should *not* be the basis for assigning priorities. For example, the identification of maintaining competence should not be undertaken until after a description of an orderly process for certification can be developed and serve as a frame of reference.

Sponsoring Organizations

The Task Group preferred the Council of Health Organizations of the Association of Schools of Allied Health Professions as the sponsoring organization. Others suggested are the Coalition of Independent Health Organizations, a group of health organizations selected for unique capabilities in undertaking a study, and the Committee for National Health Insurance.

Study Advisory Group

Study advisory groups or committees should include representatives of

- The Public (Consumer)
- Independent Practice in a Profession
- "Large" Medical Center
- Educational Institutions
- Rural Medical Center
- Practitioners
- Inner City Health Facilities
- Suburban Health Facilities
- Ethnic Groups
- Geographic Areas
- Government
- Participants in this Conference.

Funding

The Task Group members discussed the possibilities of funding from private foundation and federal sources, recognizing advantages and disadvantages of each. They agreed that the selection of sources will depend upon availability of funds and conditions imposed by the funding agency which they could not predict with reliability.

Finally, the Task Group members recommend an amendment to the definition of Certification as presently listed in the Source Book for the Invitational Conference on Certification in Allied Health (September 7-10, 1971, Glossary, p. A-11. The *underlined* words are inserted into the Glossary definition.

"Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met *and continues to meet* certain *competency* qualifications specified by that agency or association."

Moderator's Note: Suggest another revision: "... certain qualifications for competence specified by that agency or association." This change is suggested in recognition of the absence of the word "competency" from the Glossary.

TASK GROUP VIII

YES—There is a need to study credentialing with a major emphasis on certification.

- Should be a joint study with the allied health professions taking the leadership role, either through ASAHP in an expanded role, or through another broadly-focused organization crossing discipline lines.
- At same time our group urges prompt action at an early date.

Areas of concern for consideration in the recommended study:

- The primary emphasis should be on certification which includes an investigation of the relationships of certification to other forms of credentialing.
- The mechanics of administration—Who? What?
- Social and economic implications
- Consolidation of current data available on certification
- Achieving the cooperation of the professions
- Need for national guidelines for initiating the credentialing process
- Need to develop minimum credentialing for all health care personnel, at all levels
- Definition of the purpose of credentialing
- Determination of the success and/or need for improvement of credentialing in regard to:
 - *For Protection of the Public (Consumer)*
 - Competence to enter profession
 - Continuing competence to remain in profession
 - Ethical practices
 - *For Protection of Practitioner*
 - Identification of qualifications
 - Exclusion of the unqualified
 - Definition of role for each level
 - Economic security
 - *For Protection of Employer*
 - Due care in selection
 - Economic guidelines
 - Criteria utilized in certification
 - Implication for career mobility
 - Unwarranted proliferation of allied health professions
 - Need for the development of peer relationships with other health professions.

Recommended that there be established a mechanism for a unified voice of the allied health professions to speak for "their" concerns.

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